

Report: E401773R
 Office: Minneapolis Claim Office
 Date Of Report: 08/26/2022

The Hartford - Benefit Management Services

Page 1

Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

02/02/2022 01:39:54 p.m. ET Claim A Batch N/A Simsbury MAILRECEIPT-EDM

Type: Correspondence-EDM

02-FEB-22: Received Electronic Document with PCN: 30051202202025090454

Content : Correspondence - DCN : 30051202202025090454001

02/20/2021 07:55:45 a.m. ET Jacquelyn Blunt MANAGER Maitland GENERAL

Type: Tax

Email communication sent to claimants that tax forms were mailed 1/26/21 but USPS is delayed, so they can go onto our portal to view and print tax forms.

03/22/2020 04:42:50 p.m. ET Chryse Hausenfluck Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

so: recvd no med/ term claim task

AP: bend

03/10/2020 04:43:05 p.m. ET Claim A Batch N/A Simsbury EMAIL/TEXT

Type: Alerts

2020-03-10 12:30:37 CENTRAL TIME: Approval (Status change): Sent: EMAIL

03/10/2020 02:22:46 p.m. ET Chryse Hausenfluck Examiner Minneapolis PHONE CALL

Type of Call: Outgoing

Date of Call: 03/10/2020

Call To/From: Claimant

Name: Jennifer Mueller

Conversation with:

Phone: (218) 428-0953

Extension:

Fax Number:

Not Contacted: Left Message

c/o to advise daw check

advised to turn in LTD paperwork if you want to apply for that claim

no naswer, lf tvn

03/09/2020 09:39:25 a.m. ET Chryse Hausenfluck Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

From: Hausenfluck, Chryse (GB and WC Claims)

Sent: Monday, March 09, 2020 6:39 AM

To: Pevehouse, Katelyn (GB and WC Claims) <Katelyn.Pevehouse@thehartford.com>

Report: E401773R
 Office: Minneapolis Claim Office
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Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

Subject: FW: Jennifer Mueller - 9005440032 [CONFIDENTIAL]

Good morning,

I am hopping you can help me with this question I got from an ER.

?Also, I had a discussion with her today. She wanted to know if her LTD is approved and her FTE changes officially from a .9 to a .5 would she lose the LTD benefit since she goes permanently part time??

Will her claim be impacted if this occurs? She is doing DAW if that affects your answer.

Thank you,

03/09/2020 09:36:12 a.m. ET Chryse Hausenfluck Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

From: Hausenfluck, Chryse (GB and WC Claims)

Sent: Monday, March 09, 2020 6:36 AM

To: 'Tammy Kilmer' <Tamison.A.Kilmer@kp.org>

Subject: RE: Jennifer Mueller - 9005440032

Good morning,

I have not heard back from the analyst that was attached to her long term claim. I am going to try and reach out another analyst when she gets in the office to see if I can get an answer for you. In addition Jennifer will need to fill out and send in the LTD paperwork if she wants a claim to be considered. It was originally sent to her in September 2019 and again at the end of January 2020 when she requested it be sent to her again, but never sent anything back.

As for her STD claim, I will have it completed tomorrow. At that time I will be able to tell her exactly how much I can send.

Thank you,

03/09/2020 09:23:37 a.m. ET Chryse Hausenfluck Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

Jennifer Mueller

pde 3797.31

\$105.48/hr

GWB 2278.39

8/12-8/18 3841.83 not disabled

8/19-8/25 3841.83 not disabled

8/26-9/1 2997.99 2997.99+2278.39=5276.38-3797.31=1479.07 offset

9/2-9/8 2997.99 2997.99+2278.39=5276.38-3797.31=1479.07 offset

Report: E401773R
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Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

9/9-9/15 2713.42 2713.42+2278.39=4991.81-3797.31=1194.5 offset

9/16-9/23 2713.42 2713.42+2278.39=4991.81-3797.31=1194.5 offset

03/04/2020 06:32:03 a.m. ET Claim A Batch N/A Simsbury EMAILRECEIPT-EDM

Type: Correspondence-EDM

03-MAR-20: Received Electronic Document with PCN: 30051202003032001724

Content : Correspondence - DCN : 30051202003032001724001

02/13/2020 02:06:31 p.m. ET Chryse Hausenfluck Examiner Minneapolis PHONE CALL

Type of Call: Outgoing

Date of Call: 02/13/2020

Call To/From: Claimant

Name: Jennifer Mueller

Conversation with:

Phone: (218) 428-0953

Extension:

Fax Number:

c/o to ee to advise was informed she got full pay with hours and pto during period in question
 ee advised that it was future pto they offered to use for her
 ee will see if she can reugest they take it back and resend somthing over
 ee thnaked

02/13/2020 02:00:01 p.m. ET Chryse Hausenfluck Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

From: Tammy Kilmer [mailto:Tamison.A.Kilmer@kp.org]

Sent: Thursday, February 13, 2020 10:20 AM

To: Hausenfluck, Chryse (GB and WC Claims) <Chryse.Hausenfluck@thehartford.com>

Subject: RE: Jennifer Mueller - 9005440032

Hi Chryse,

That is correct.

Thank you,

Tammy Kilmer (?she/her?)

Senior Benefit Analyst

Human Resources

Permanente Medicine

Northwest Permanente, PC

500 NE Multnomah Street, Ste. 100, 15th Floor

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Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

Portland, OR 97232-2023

503-813-2235 (office)

49-2235 (tie-line)

503-813-4412 (Benefit Department Group Line)

49-4412 (Benefit Department Group tie-line)

Fax: 503-813-2395

Email: NWP-BenefitsTeam@kp.org

Email: tamison.a.kilmer@kp.org

02/10/2020 03:26:56 p.m. ET Chryse Hausenfluck Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

From: Hausenfluck, Chryse (GB and WC Claims)

Sent: Monday, February 10, 2020 1:26 PM

To: 'Tammy Kilmer' <Tamison.A.Kilmer@kp.org>

Subject: RE: Jennifer Mueller - 9005440032

Good afternoon,

I had the chance to review the pay you sent over for Jennifer. If I am reading it correctly she received her full from 8/11/19 through 9/21/19 with the combination of her worked hours and sick time?

Thank you,

02/10/2020 03:26:40 p.m. ET Chryse Hausenfluck Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

so: recvd finacial task. reviewed. looks like ee got full pay with the use of sickitme.

ap: emailing er to confirm

02/05/2020 12:19:38 p.m. ET Claim A Batch N/A Simsbury EMAILRECEIPT-EDM

Type: Financial-EDM

05-FEB-20: Received Electronic Document with PCN: 30051202002052000643

Content : Correspondence - DCN : 30051202002052000643001

Financial - DCN : 30051202002052000643002

Report: E401773R
 Office: Minneapolis Claim Office
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Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

02/04/2020 06:13:54 p.m. ET Chryse Hausenfluck Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

From: Hausenfluck, Chryse (GB and WC Claims)
 Sent: Tuesday, February 04, 2020 4:13 PM
 To: 'tamison.a.kilmer@kp.org' <tamison.a.kilmer@kp.org>
 Subject: Jennifer Mueller - 9005440032 [CONFIDENTIAL]

Good afternoon,

Can you please fill out the attached template for Jennifer covering 8/12/19 through 9/15/19 for her part time work?

Thank you,

01/27/2020 02:56:31 p.m. ET Chryse Hausenfluck Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

From: Hausenfluck, Chryse (GB and WC Claims)
 Sent: Monday, January 27, 2020 12:09 PM
 To: 'fjeanette96@yahoo.com' <fjeanette96@yahoo.com>
 Subject: Contact Information - 9005609739

Good afternoon

Thank you for taking my call today. My contact information is below. Please reach out via phone or email if you have any questions or concerns.

Thank you,

01/27/2020 02:54:07 p.m. ET Chryse Hausenfluck Examiner Minneapolis PHONE CALL

Type of Call: Incoming

Date of Call: 01/27/2020

Call To/From: Claimant

Name: Jennifer Mueller

Conversation with:

Phone: (218) 428-0953

Extension:

Fax Number:

ee ci to disucss claim
 ee advised never heard back from LTD, but still out pt
 advised i will request ltd paperwork be remailed to her
 advised i will request her pay for the last month of short term disability
 ee thanked

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Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

10/15/2019 12:59:24 p.m. ET Chryse Hausenfluck Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

so: recvd no med/ term claim task

AP: ee hit bend, have set up LTD referral

09/25/2019 02:27:52 p.m. ET Chryse Hausenfluck Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

so: recvd coorespondence task

ap: reviewed closing. ee sent it to me for FICA purpouses, then i emailed it to her file.

09/23/2019 06:31:22 a.m. ET Claim A Batch N/A Simsbury MAILRECEIPT-EDM

Type: Checks-EDM

23-SEP-19: Received Electronic Document with PCN: 30051201909215090004

Content : Checks - DCN : 30051201909215090004001

09/23/2019 06:31:22 a.m. ET Claim A Batch N/A Simsbury MAILRECEIPT-EDM

Type: Correspondence-EDM

23-SEP-19: Received Electronic Document with PCN: 30051201909202001259

Content : Correspondence - DCN : 30051201909202001259001

09/18/2019 08:10:04 p.m. ET Claim A Batch N/A Simsbury EMAIL/TEXT

Type: Alerts

2019-09-18 12:45:44 CENTRAL TIME: Approval (Status change): Sent: EMAIL

09/18/2019 04:34:17 p.m. ET Claim A Batch N/A Simsbury EMAILRECEIPT-EDM

Type: Correspondence-EDM

18-SEP-19: Received Electronic Document with PCN: 30051201909182001265

Content : Correspondence - DCN : 30051201909182001265001

09/18/2019 03:04:38 p.m. ET Chryse Hausenfluck Examiner Minneapolis PHONE CALL

Type of Call: Outgoing

Date of Call: 09/18/2019

Call To/From: Claimant

Report: E401773R
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Comments: Summary Detail Report
 Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

Name: Jennifer Mueller

Conversation with:

Phone: (218) 428-0953

Extension:

Fax Number:

c/o to ee to advise i have requested a LTD claim be set up for her
 advised i have a DAW check ready to go for her, but waiting to see FICA before releaseing the check
 will email ee that way if she can find her paystub, she can send it in.
 ee thanked

09/18/2019 02:52:45 p.m. ET Chryse Hausenfluck Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

Jennifer Mueller

100% of PDE

PDE 3797.31 40 hrs per wk \$94.93/hr GWB 2278.39

hours

5/20/19-5/26/19	14.5	14.5x94.93=1376.49+2278.39=3654.88	no offset needed
5/27/19-6/2/19	14.5	14.5x94.93=1376.49+2278.39=3654.88	no offset needed
6/3/19-6/9/19	18	18x94.93=1708.74+2278.39=3987.13-3797.31=	\$189.82 offset
6/10/19-6/16/19	18	18x94.93=1708.74+2278.39=3987.13-3797.31=	\$189.82 offset
6/17/19-6/23/19	20	20x94.93=1898.60+2278.39=4176.99-3797.31=	\$379.68 offset
6/24/19-6/30/19	20	20x94.93=1898.60+2278.39=4176.99-3797.31=	\$379.68 offset
7/1/19-7/7/19	18	18x94.93=1708.74+2278.39=3987.13-3797.31=	\$189.82 offset
7/8/19-7/14/19	18	18x94.93=1708.74+2278.39=3987.13-3797.31=	\$189.82 offset
7/15/19-7/21/19	20	20x94.93=1898.60+2278.39=4176.99-3797.31=	\$379.68 offset
7/22/19-7/28/19	20	20x94.93=1898.60+2278.39=4176.99-3797.31=	\$379.68 offset
7/29/19-8/4/19	20	20x94.93=1898.60+2278.39=4176.99-3797.31=	\$379.68 offset
8/5/19-8/11/19	20	20x94.93=1898.60+2278.39=4176.99-3797.31=	\$379.68 offset

09/18/2019 02:51:56 p.m. ET Chryse Hausenfluck Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

From: Hausenfluck, Chryse (GB and WC Claims)

Sent: Wednesday, September 18, 2019 11:47 AM

To: 'Jenna G Larsen' <Jenna.G.Larsen@kp.org>; 'ashley.r.koski@kp.org' <ashley.r.koski@kp.org>

Subject: Jennifer Mueller-9005440032

Good afternoon,

I received the medical update from Dr. Mueller's doctor and am ready to issue her a check for her part time work. Before I do so, can you please advise if/when she hit the FICA threshold? I don't want to withhold extra taxes from her check if I don't have to.

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Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

Thank you,

09/16/2019 01:57:38 p.m. ET Claim A Batch N/A Simsbury FAXRECEIPT-EDM

Type: APS-EDM

16-SEP-19: Received Electronic Document with PCN: 30051201909161001425

Content : APS - DCN : 30051201909161001425001

Claim Form - Authorizations DCN : 30051201909161001425002

09/10/2019 04:30:17 p.m. ET Denise Osbourne Examiner Maitland PHONE CALL

Type of Call: Incoming

Date of Call: 09/10/2019

Call To/From: Claimant

Name: Jennifer Mueller

Conversation with:

Phone: (218) 428-0953

Extension:

Fax Number:

EE New contact number 5032179161

EE ci regrads to transitioning to LTD

Adv the STD duration is 25 weeks

EE stated she has rtn to work at 60% instead 100%

Adv I can set a f/u for AA to further assist with LTD claim process

Task set

09/04/2019 09:21:34 p.m. ET Chryse Hausenfluck Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

so: recvd financial task

ap: reviewed. closing task. awaiting medical before i can look at DAW

09/03/2019 09:23:23 a.m. ET Claim A Batch N/A Simsbury EMAILRECEIPT-EDM

Type: Financial-EDM

03-SEP-19: Received Electronic Document with PCN: 30051201909032000135

Content : Correspondence - DCN : 30051201909032000135001

Financial - DCN : 30051201909032000135002

09/02/2019 06:45:06 p.m. ET Chryse Hausenfluck Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

sent request for MR's

Report: E401773R
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Comments: Summary Detail Report
 Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

08/26/2019 05:15:11 p.m. ET Chryse Hausenfluck Examiner Minneapolis PHONE CALL

Type of Call: Outgoing

Date of Call: 08/26/2019

Call To/From: Claimant

Name: Jennifer Mueller

Conversation with:

Phone: (218) 428-0953

Extension:

Fax Number:

c.o to ee to rt her vm

ee stated her questions on why she made to much for DAW were answered by her HR

ee had questions about LTD and if she would qualify, advised it wouldnt hurt to fill out application.

ee thanked

08/23/2019 04:51:44 p.m. ET Elena M Roque Examiner Simsbury PHONE CALL

Type of Call: Incoming

Date of Call: 08/23/2019

Call To/From: Claimant

Name: Jennifer Mueller

Conversation with:

Phone: (218) 428-0953

Extension:

Fax Number:

ee c/i to rcvd call from aa adv denied

ee adv is not understanding how the determination was made, ee adv left VM for aa

ee inquired about LTD, adv ee ltd app can be mailed out, adv ee ltd aa will be assigned after app rcvd

ee adv will wait for aa to c/b

ee thanked

08/23/2019 04:20:36 p.m. ET Chryse Hausenfluck Examiner Minneapolis PHONE CALL

Type of Call: Outgoing

Date of Call: 08/23/2019

Call To/From: Claimant

Name: Jennifer Mueller

Conversation with:

Phone: (218) 428-0953

Extension:

Fax Number:

Not Contacted: Left Message

c/o to ee as she had questions regaurding DAW

advised it looks like she made too much money, didnt qualify.

no answer, lft vm.

06/21/2019 07:05:50 a.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

sp; tc's rec'd, current aed 5/19, ee rtw PT on 5/20, not elig for daw from 5/20 thru 6/15

ap; term claim

Current Weekly Earnings will not be used to reduce Your Weekly Benefit. However, if the sum of Your Weekly Benefit and Your Current Weekly Earnings exceeds 100% of Your Pre-disability Earnings, the Employer will reduce Your Weekly Benefit by the amount of the excess.

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Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

Benefit Effective Date:

Date Ill Bank (sick pay) Expired: 6/3/2018

Date of Partial Return to Work: 5/20/2019

Date of Full Return to Work:

Documentation of Earnings Received after Ill Bank Expiration

Pay Period Number of hours worked Gross Pay less Vacation*

6/2-6/15 44

\$4,757.37

5/19-6/1 37

5/5-5/18 8

Calculated Earnings

\$7,683.65

\$2,926.28

\$7,683.65 \$2,403.73

\$5,279.92

\$3,255.30 \$1,567.65

\$1,687.65

06/20/2019 04:49:09 p.m. ET Claim A Batch N/A Simsbury EMAILRECEIPT-EDM
 Type: Financial-EDM

20-JUN-19: Received Electronic Document with PCN: 30051201906202001341

Content : Correspondence - DCN : 30051201906202001341001

Financial - DCN : 30051201906202001341002

06/19/2019 06:34:29 a.m. ET Claim A Batch N/A Simsbury EMAILRECEIPT-EDM
 Type: Financial-EDM

18-JUN-19: Received Electronic Document with PCN: 30051201906182001732

Content : Correspondence - DCN : 30051201906182001732001

Financial - DCN : 30051201906182001732002

06/17/2019 02:51:11 p.m. ET Vanessa Z Jones MANAGER Maitland GENERAL
 Type: Miscellaneous

From: Jones, Vanessa (GB and WC Claims)

Sent: Monday, June 17, 2019 2:51 PM

To: 'Jenna G Larsen'

Cc: Bergeson, Jen (GB and WC Claims)

Subject: Earnings for Dr Mueller [CONFIDENTIAL]

Hi Jenna,

Are you able to complete the attached spreadsheet for Dr Mueller please?

She began working part time effective 5/20/2019. If you can complete as much as you can, so we can review for additional benefits beyond 5/19.

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Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

Thanks!

06/17/2019 11:27:24 a.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

email sent to AM to help obtain tcs, pushing out f/u task

06/09/2019 08:38:14 a.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

f/u email sent to er for tc's

05/31/2019 07:13:07 a.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

email to er for tc's:

'Jenna.G.Larsen@kp.org' Fri 5/31/2019 7:13 AM

Good morning Jenna,

Can you please fill out the spreadsheet for the part-time hours worked for this employee:

JENNIFER E MUELLER, 9005440032

We are in need of 5/20 ? current.

Thank you,

JEN BERGESON

Sr. Ability Analyst

Short Term Disability, Group Benefits Claims

Normal Business Hours: M-F 7am to 3:30pm EST

The Hartford Financial Services Group, Inc.

PO Box 14302

Lexington, KY 40512-4302

W: 800-707-5333 ext. 2308113

F 866-411-5613 (Please include Insured ID # on all correspondence)

jennifer.bergeson@thehartford.com

Report: E401773R
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Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

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Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

05/31/2019 07:08:39 a.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

email from ee:

Jennifer Mueller <madamezola@gmail.com> Thu 5/30/2019 12:43 PM

Hi Jennifer,

I wanted to touch base about my return to work. I am back to work half time right now and my schedule is ramping up slowly over the next several weeks. I don't know if you need the specific schedule or if you'll just use my paystubs to figure out how much I'm working or not working. Here is the tentative return to work schedule at this time.

Restrictions:

5/20-6/1: Work 4 hours per day x4 days a week. Patient appointments limited to 2 per hour.

6/2-6/8: Work 4 hours per day x5 days a week. Patient appointments limited to 2 per hour (virtual visits limited to 3 per hour).

6/9-6/15: Increase to 6 sessions per week (4 hours per session). Patient appointments limited to 2 per hour (virtual visits limited to 3 per hour).

6/16-6/22: Increase to 7 sessions per week (4 hours per session). Patient appointments limited to 2 per hour (virtual visits limited to 3 per hour).

6/23-6/29: Increase to 8 sessions per week (4 hours per session). Patient appointments limited to 2 per hour (virtual visits limited to 3 per hour).

6/30 onward: Continue 8 sessions per week. Return to regular templated scheduled.

This is return to full duty 6/30/2019.

I'm available today (Thursday) and tomorrow morning if we need to chat.

Jennifer Mueller

05/13/2019 07:43:06 p.m. ET Claim A Batch N/A Simsbury EMAIL/TEXT

Type: Alerts

2019-05-13 15:52:41 CENTRAL TIME: RTW AM: RETURN: EMAIL

05/13/2019 03:38:08 p.m. ET Claim A Batch N/A Simsbury EMAIL/TEXT

Type: Alerts

2019-05-13 10:28:52 CENTRAL TIME: RTW AM: Sent: EMAIL

05/07/2019 10:13:54 a.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT

Report: E401773R
 Office: Minneapolis Claim Office
 Date Of Report: 08/26/2022

The Hartford - Benefit Management Services

Page 13

Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

ext email:

'Jennifer Mueller' <madamezola@gmail.com> Tue 5/7/2019 10:14 AM

Good morning Jen,

I have reviewed a recent medical update from your Physician and have extended your claim through 05/19/19. I will send for timecards for the period of 5/20 through 6/2 once we reach the date that you return to work part-time. I find that your claim is medically supported through 6/2 and I do not need any additional medical information at this time. A new medical update will be needed for any duration beyond 6/2.

Best regards,

JEN BERGESON

Sr. Ability Analyst

Short Term Disability, Group Benefits Claims

Normal Business Hours: M-F 7am to 3:30pm EST

05/07/2019 10:09:58 a.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

so, med and aps rec'd 5/6, current aed 5/12; ap indicates ee rrtw PT for 5/20 thru 6/2, r/l's: can work no more than 4 hrs per day due to ongoing fatigue / photophobia / reduced tolerance to read or screen time and vertigo with getting up quickly, physical exam findings: hallpike produces vertigo and brief nystagmus with left ear dependant / II-12 intact to bedside esophoria OD, ee to continue symmetrel 100 mg and desyrel 100 mg / PT / ST / OT / eye care / PHY / and ENT, LOV 5/2, NOV 5/21

ap; ext thru 5/19, will ext thru 6/2 with tc's, set task to obtain tc's

05/06/2019 06:49:21 p.m. ET Claim A Batch N/A Simsbury FAXRECEIPT-EDM

Type: APS-EDM

06-MAY-19: Received Electronic Document with PCN: 30051201905061003312

Content : APS - DCN : 30051201905061003312001

Medical Records - DCN : 30051201905061003312002

Claim Form - Authorizations DCN : 30051201905061003312003

05/06/2019 02:18:57 p.m. ET Jennifer Bergeson Examiner Minneapolis PHONE CALL

Type of Call: Incoming

Date of Call: 05/06/2019

Call To/From: Claimant

Report: E401773R
 Office: Minneapolis Claim Office
 Date Of Report: 08/26/2022

The Hartford - Benefit Management Services

Page 14

Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

Name: Jennifer Mueller

Conversation with:

Phone: (218) 428-0953

Extension:

Fax Number:

ibc from ee to return aa's req for c/i, aa advised will need med to ext thru PT rtw, will ext thru 5/12 while waiting for med, ee to email aa additional providers and thanked

05/06/2019 09:50:57 a.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

email to ee:

'Jennifer Mueller' <madamezola@gmail.com> Mon 5/6/2019 9:51 AM

Good morning Jennifer,

I received your voicemail regarding your part-time return to work dates, 5/20 through 6/1, but I have still not receive a medical update from your Physician. I asked Jenna Larsen to help investigate the request for records and she responde that your Physician is not responding to the request. Please contact me today to discuss how to obtain the information needed to get your claim extended for you.

Best regards,

JEN BERGESON

Sr. Ability Analyst

Short Term Disability, Group Benefits Claims

Normal Business Hours: M-F 7am to 3:30pm EST

05/03/2019 05:27:26 p.m. ET Claim A Batch N/A Simsbury EMAIL/TEXT

Type: Alerts

2019-05-03 12:38:26 CENTRAL TIME: RTW AM: STAY: EMAIL

04/29/2019 02:45:20 p.m. ET Claim A Batch N/A Simsbury EMAIL/TEXT

Type: Alerts

2019-04-29 10:08:34 CENTRAL TIME: RTW AM: Sent: EMAIL

04/19/2019 08:00:59 a.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

Report: E401773R
Office: Minneapolis Claim Office
Date Of Report: 08/26/2022

The Hartford - Benefit Management Services

Page 15

Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

response from er:

Hi Jennifer,

ROI did get the request for the Jennifer Mueller. The issue is the doctor is not responding to the request. They are working to get this completed.

Thanks,

Jenna

From: TAMI T TORREY
Sent: Wednesday, April 17, 2019 9:26 AM
To: Jenna G Larsen <Jenna.G.Larsen@kp.org>
Subject: RE: Jennifer Mueller (phi)

Hi Jenna,

I sent a message to our specialist on this one and she just sent a reminder to the doctor on it. I hope this does it.

Tami T. Torrey
Customer Service Liaison
Release of Information

Kaiser Permanente
Regional Process Center
10220 SE Sunnyside Road
Clackamas, OR 97015

Report: E401773R
Office: Minneapolis Claim Office
Date Of Report: 08/26/2022

The Hartford - Benefit Management Services

Page 16

Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

503-571-5001 (office)

31-5001 (tie-line)

855-414-2288 (fax)

Health Information Management logo

Please visit us at our new website: kp.org/releaseofinformation

From: Jenna G Larsen

Sent: Wednesday, April 17

04/18/2019 01:59:43 p.m. ET Claim A Batch N/A Simsbury FAXRECEIPT-EDM
Type: Medical Records-EDM

18-APR-19: Received Electronic Document with PCN: 30051201904181001869

Content : Correspondence - DCN : 30051201904181001869001

Claim Form - Authorizations DCN : 30051201904181001869002

Medical Records - DCN : 30051201904181001869003

04/17/2019 02:49:08 p.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT
Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

ext approval, email to ee:

'Jennifer Mueller' <madamezola@gmail.com> Wed 4/17/2019 2:48 PM

Good news!

I received a medical update on you an hour ago. I've extended your claim through 5/5. There was no mention of returning to work part-time on the statement. Do you think you'll return full-time on the 6th?

Jen

From: Jennifer Mueller [<mailto:madamezola@gmail.com>]

Sent: Wednesday, April 17, 2019 11:34 AM

To: Bergeson, Jennifer (GB and WC Claims)

Subject: Re: Your STD claim 9005440032 [CONFIDENTIAL]

Thanks for the update Jen. Last I talked with them they said they needed the signed ROI, which I told them and already been submitted. She said she would recheck and email me if I needed to resend it directly to them and I didn't hear back from her. If you need something directly from my physician, when I last talked to her 4/11 she said she hadn't received

STD AR 000016

Report: E401773R
 Office: Minneapolis Claim Office
 Date Of Report: 08/26/2022

The Hartford - Benefit Management Services

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Comments: Summary Detail Report
 Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

any forms yet, but that was a week ago so not sure now. Let me know if I need to light a fire under someone.

Jennifer

Sent from my iPhone, so there's probably a bunch of typos and grammatical errors.

On Apr 17, 2019, at 6:15 AM, Bergeson, Jennifer (GB and WC Claims) <Jennifer.Bergeson@thehartford.com> wrote:
 Good morning Jennifer,

I still have not received any medical information from the medical records department. I sent an email over to Jenna Larsen this morning to see if she can help assist. I'll keep you updated as I know more.

Best regards,

JEN BERGESON

Sr. Ability Analyst

Short Term Disability, Group Benefits Claims

Normal Business Hours: M-F 7am to 3:30pm EST <image001.gif>

The Hartford Financial Services Group, Inc.

PO Box 14302

Lexington, KY 40512-4302

W: 800-707-5333 ext. 2308113

F 866-411-5613 (Please include Insured ID # on all correspondence)

jennifer.bergeson@thehartford.com

<image002.png> Named one of the World's Most Ethical Companies for the 9th time by the Ethisphere? Institute.

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twitter.com/thehartford

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04/17/2019 02:46:12 p.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

STD AR 000017

Report: E401773R
 Office: Minneapolis Claim Office
 Date Of Report: 08/26/2022

The Hartford - Benefit Management Services

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Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

so; aps rec'd 4/17, current aed 5/2, ap indicates ee in need of additional recovery from postconcussion syndrome / insomnia / mild cog impairment, current tx plan: med, rest, PT, OT, speech and lang therapy, eye care, physiatry, ENT; ap indicates unable to work thru ertw 5/6

ap; reasonable to ext thru ertw att to allow ee to finsh tx needed to regain normal cog as ee unable to perform fjd's o a physician att

04/17/2019 01:45:47 p.m. ET Claim A Batch N/A Simsbury FAXRECEIPT-EDM
 Type: APS-EDM

17-APR-19: Received Electronic Document with PCN: 30051201904171001855
 Content : APS - DCN : 30051201904171001855001

04/17/2019 09:15:53 a.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT
 Recommendation/Plan: Examiner Claim Management Plan Sign off required: N

email to ee:

'MADAMEZOLA@GMAIL.COM' Wed 4/17/2019 9:16 AM

Good morning Jennifer,

I still have not received any medical information from the medical records department. I sent an email over to Jenna Larsen this morning to see if she can help assist. I'll keep you updated as I know more.

Best regards,

JEN BERGESON
 Sr. Ability Analyst
 Short Term Disability, Group Benefits Claims
 Normal Business Hours: M-F 7am to 3:30pm EST

04/17/2019 09:13:41 a.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT
 Recommendation/Plan: Examiner Claim Management Plan Sign off required: N

email to er:

Jenna G Larsen <Jenna.G.Larsen@kp.org>
 Jones, Vanessa (GB and WC Claims) <vanessa.jones1@thehartford.com>
 Wed 4/17/2019 9:13 AM

Report: E401773R
Office: Minneapolis Claim Office
Date Of Report: 08/26/2022

The Hartford - Benefit Management Services

Page 19

Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

Good morning Jenna,

I've sent several ROI requests for: JENNIFER E MUELLER, 9005440032 but have not gotten anything back yet. My last attempt was on 4/12. Are you able to assist?

Thank you!

JEN BERGESON
Sr. Ability Analyst
Short Term Disability, Group Benefits Claims
Normal Business Hours: M-F 7am to 3:30pm EST

04/12/2019 12:48:11 p.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

'NW.ROI@kp.org' Fri 4/12/2019 12:48 PM

2nd request ? please respond

ATHORIZATION ATTACHED

JENNIFER E MUELLER, DOB REDACTED, Kaiser Med rec# 73745976 - Twallaton office

Please send all records from 3/18/19 through present from treating provider: DR. KATHLEEN LAUGHLIN

Please have Physician complete attached form.

PLEASE FAX BACK TO 866-411-5613 include Insured ID # 9005440032

JEN BERGESON
Sr. Ability Analyst
Short Term Disability, Group Benefits Claims
Normal Business Hours: M-F 7am to 3:30pm EST

04/12/2019 12:45:14 p.m. ET Jennifer Bergeson Examiner Minneapolis PHONE CALL

Type of Call: Outgoing

Date of Call: 04/12/2019

Call To/From: Claimant

Name: Jennifer Mueller

Conversation with:

Phone: (218) 428-0953

Extension:

Fax Number:

obc to ee to return ee's vm, ee states 1st OT session on 4/8, ee found session difficult, continues nausea when reading

Report: E401773R
 Office: Minneapolis Claim Office
 Date Of Report: 08/26/2022

The Hartford - Benefit Management Services

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Comments: Summary Detail Report
 Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

and viewing computer screens, is mentally exhausted / feels motion sickness when scrolling through screens or while reading, experiences letter shaddowing, and continues dizziness, LOV 4/11, NOV with opthomarist on 5/2, will need prizi glasses to correct symptoms, would like to rtw PT at some point, aa advised still awaiting med, will send 2nd req, advised will ext thru 5/5 att considering contiued symptoms and need for f/u with specialist, please c/i to update aa after NOV 5/2, ee is agreeable and thanked

04/11/2019 04:42:43 p.m. ET Claim A Batch N/A Simsbury EMAIL/TEXT
 Type: Alerts

2019-04-11 10:07:08 CENTRAL TIME: RTW AM: STAY: EMAIL

04/10/2019 01:12:09 p.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT
 Recommendation/Plan: Examiner Claim Management Plan Sign off required: N

pushing out f/u med task, req on 4/4

04/08/2019 05:04:44 p.m. ET Claim A Batch N/A Simsbury EMAIL/TEXT
 Type: Alerts

2019-04-08 10:10:09 CENTRAL TIME: RTW AM: Sent: EMAIL

04/04/2019 03:46:47 p.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT
 Recommendation/Plan: Examiner Claim Management Plan Sign off required: N

email to ROI:

'NW.ROI@kp.org' Thu 4/4/2019 3:44 PM

ATHORIZATION ATTACHED

JENNIFER E MUELLER, DOB REDACTED, Kaiser Med rec# 73745976 - Twallaton office

Please send all records from 3/18/19 through present from treating provider: DR. KATHLEEN LAUGHLIN

Please have Physician complete attached form.

PLEASE FAX BACK TO 866-411-5613 include Insured ID # 9005440032

04/04/2019 03:46:07 p.m. ET Jennifer Bergeson Examiner Minneapolis PHONE CALL
 Type of Call: Incoming Date of Call: 04/04/2019 Call To/From: Claimant

Report: E401773R
 Office: Minneapolis Claim Office
 Date Of Report: 08/26/2022

The Hartford - Benefit Management Services

Page 21

Comments: Summary Detail Report
 Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner
 Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740
 Case: Northwest Permanente, P.C.
 Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

Name: Jennifer Mueller

Conversation with:

Phone: (218) 428-0953

Extension:

Fax Number:

ibc from ee, ee states: NOV 4/11, dizziness continues, may be referred to occ therapy, unsure if ext needed, please fax request in case, aa advised will email ROI / please f/u with aa after 4/11 OV, advised will ext if needed while waiting for med, ee thanked

04/04/2019 03:27:02 p.m. ET Amber Morris Examiner Minneapolis PHONE CALL

Type of Call: Incoming

Date of Call: 04/04/2019

Call To/From: Claimant

Name: Jennifer Mueller

Conversation with:

Phone: (218) 428-0953

Extension:

Fax Number:

EE c/i req for APS to be sent to ROI departmnt. Prov F: 503-571-2624. EE also req to spk to AA.
 Faxed Caps, xfr to AA with vm expectations.
 'Release_of_Information_Department._.5035712624@fax2mail.com'

04/02/2019 10:56:30 a.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

email to ee:

'MADAMEZOLA@GMAIL.COM' Tue 4/2/2019 10:56 AM

Good morning,

I am writing to advise you that I am approving your STD claim. Your Date of Disability is 03/18/19. Your claim has been approved through 04/14/19. Please reach out to me approximately two weeks prior to that date if you think that you'll need an extension. I would be happy to fax the appropriate forms to your Physician on your behalf. Once a medical update is received and reviewed I will reach out to you to advise of the extension decision.

Please note:

1. Do not respond to this email for extension requests, please reach me at the phone number listed below or you may also request an extension online;
2. A return to work note cannot be accepted as medical evidence that disability is supported beyond your current Authorized End Date.

Your Gross Weekly Benefit is: \$2278.39. Your benefits became payable on 03/25/19. This is due to having to satisfy the waiting period on your policy. Your first payment will be issued today in the amount of \$2998.18. This payment is good for the following dates: From 03/25/19 through 04/07/19. Please don't forget that for Direct Deposit, it can take up to two business days to receive the funds from the date that they were released; it can take up to eight business days to receive paper checks in the mail.

Please note the following:

Report: E401773R
 Office: Minneapolis Claim Office
 Date Of Report: 08/26/2022

The Hartford - Benefit Management Services

Page 22

Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

1. Some payments may be prorated depending on what day of the week the payment is released;
2. 2. Your benefit may be subject to taxation.

To set up Direct Deposit or for other claim information please visit: <https://mybenefits.thehartford.com/login>

For any questions regarding your claim I would like to kindly ask you to call me during my normal business hours. Please do not respond to this email directly as I would like to address any questions or concerns as quickly as possible.

You will find my contact information below. Please note that my normal business hours are M-F from 7am - 3:30pm EST. If you ever have to leave me a voicemail or send me an email, please always be sure to include your Insured ID # 9005440032.

You may also receive a survey from the Hartford to this email address. Would you mind taking a few minutes to complete it? Please let me know how I'm doing for you, I would really appreciate your feedback!

Best regards,

JEN BERGESON
 Sr. Ability Analyst
 Short Term Disability, Group Benefits Claims
 Normal Business Hours: M-F 7am to 3:30pm EST

The Hartford Financial Services Group, Inc.
 PO Box 14302
 Lexington, KY 40512-4302

W: 800-707-5333 ext. 2308113
 F 866-411-5613 (Please include Insured ID # on all correspondence)
jennifer.bergeson@thehartford.com

04/02/2019 10:47:48 a.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

response from er: no salcon paid beyond EP, BEFD 3/25

HI,

Her sick time ended on Friday 3/22. After that date no more sick time

From: Bergeson, Jennifer (GB and WC Claims) <Jennifer.Bergeson@thehartford.com>
 Sent: Monday, April 1, 2019 4:20 AM
 To: Jenna G Larsen <jenna.g.larsen@kp.org>
 Subject: Sick pay confirmation 9005440032 [CONFIDENTIAL]

STD AR 000022

Report: E401773R
Office: Minneapolis Claim Office
Date Of Report: 08/26/2022

The Hartford - Benefit Management Services

Page 23

Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

Importance: High

Caution: This email came from outside Kaiser Permanente. Do not open attachments or click on links if you do not recognize the sender.

Good morning Jenna,

Can you please confirm the dates that sick pay was used for: JENNIFER E MUELLER, 9005440032.

Thank you!

JEN BERGESON

Sr. Ability Analyst

Short Term Disability, Group Benefits Claims

Normal Business Hours: M-F 7am to 3:30pm EST

04/02/2019 03:00:32 a.m. ET Claim A Batch Simsbury CLAIM MANAGEMENT

Recommendation/Plan: Claim Analytics Report

Sign off required: N

The state this claimant resides in requires written confirmation when verbal consent was obtained to initiate, modify or terminate an EFT. Review the recent EFT activity and send a letter to the claimant advising of the type of verbal EFT change that occurred.

04/01/2019 05:18:23 p.m. ET Claim A Batch N/A Simsbury MAILRECEIPT-EDM

Type: Claim Form-EDM

01-APR-19: Received Electronic Document with PCN: 30051201904013000968

Content : Correspondence - DCN : 30051201904013000968001

Claim Form - Authorizations DCN : 30051201904013000968002

04/01/2019 07:23:30 a.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Approval/Denial Recommendation

Sign off required: N

claim approved, payment on hold pending salcon confirmation, DO NOT ADVISE EE

SO: ee oow due to fractured maxilla/concussion, hit by another biker and fell fracturing and maxilla and sustained a concussion (accident form sent), no sx performed att, ertw unk

Causality: A

Functional Requirements: sit, stand, walk, lift up to 20 lbs

Job Class: 2

Standard Duration:

LDW: 3/16

Report: E401773R
 Office: Minneapolis Claim Office
 Date Of Report: 08/26/2022

The Hartford - Benefit Management Services

Page 24

Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

DOD: 3/18

GAP: nswd

BEFD: 3/25

BEND: 9/15

ER reported ERTW: unk

EE Group/Class: 1

DOH: 9/20/16

ER Reported EDOC: 9/20/16

Prior coverage? unk

PDE: \$3797.31

Salcon? TBC

Stat Offset: n/a

FICA Threshold: n/a

Benefit Amt: \$2278.39

Insured amount: \$

Taxability: 100

Communication: eob

Pre-x: n/a

A; considering nature of fx and head injury along with need for recovery and f/u care from ap, it would be appropriate to approve claim thru 28 days att

STP: approve thru 4/14

LTP: mu to ext

04/01/2019 07:20:22 a.m. ET Jennifer Bergeson Examiner Minneapolis CLAIM MANAGEMENT

Recommendation/Plan: Examiner Claim Management Plan

Sign off required: N

email to er:

'Jenna G Larsen' <Jenna.G.Larsen@kp.org> Mon 4/1/2019 7:20 AM

Good morning Jenna,

Can you please confirm the dates that sick pay was used for: JENNIFER E MUELLER, 9005440032.

Thank you!

JEN BERGESON

Sr. Ability Analyst

Short Term Disability, Group Benefits Claims

Normal Business Hours: M-F 7am to 3:30pm EST

03/29/2019 04:49:07 p.m. ET Marie Chouest Nurse Sacramento CLAIM MANAGEMENT

Report: E401773R
Office: Minneapolis Claim Office
Date Of Report: 08/26/2022

The Hartford - Benefit Management Services

Page 25

Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

Recommendation/Plan: Clinical Impression

Sign off required: N

IF DEEMED ELIGIBLE, SYSTEM GUIDELINES SUPPORT 1 DAY D/T FUNCTIONAL REQUIREMENTS OF JOB DUTIES. ANY FURTHER TIME NEEDED BEYOND THIS WILL REQUIRE AN APS INCLUDING A PE AND FUNCTIONAL LIMITATIONS OF JOB DUTIES.

03/29/2019 04:43:06 p.m. ET Marie Chouest Nurse Sacramento TELEPHONIC
Statement: Physician Type Of Intake: Phone

FT - AP Intake Auto completed

03/29/2019 04:43:06 p.m. ET Marie Chouest Nurse Sacramento TELEPHONIC
Statement: Employer Type Of Intake: Phone

Feed - ER Intake Auto completed

03/29/2019 04:43:06 p.m. ET Marie Chouest Nurse Sacramento GENERAL
Type: Initial Decision Tracker

EE Statement: 29-MAR-19
ER Statement: 29-MAR-19
AP Statement: 29-MAR-19
1st Erisa Date: 13-MAY-19
2nd Erisa Date: 12-JUN-19
3rd Erisa Date: 12-JUL-19

03/29/2019 04:43:05 p.m. ET Marie Chouest Nurse Sacramento GENERAL
Type: Electronic Funds Transfer

Is there anyone else that is authorized to use this account? If yes, note person's name. :YES JONATHAN NELSON

Do you understand that you are responsible to inform The Hartford immediately of any address changes or changes to your [bank or credit union] account information? :YES

Do you understand that the Hartford must receive a notice from you if you want to terminate this electronic transfer of funds into your account? This will allow The Hartford and the [bank or credit union] reasonable opportunity to act on your request :YES

03/29/2019 04:43:04 p.m. ET Marie Chouest Nurse Sacramento GENERAL
Type: Causality

Report: E401773R
Office: Minneapolis Claim Office
Date Of Report: 08/26/2022

The Hartford - Benefit Management Services

Page 26

Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

MAIN QUESTIONS:

What were you doing at the time the injury occurred?

(Max limit 2000 characters - approximately 50 lines) : EE WAS RIDING HER BIKE TO WORK AND WAS HIT BY ANOTHER BIKER AND
SUSTAINED A CONCUSSION AND A FRACTURED MAXILLA

Where were you when the injury occurred?(List) : OTHER-HIGHWAY

Were you working when the injury occurred?(List) : NO

Were you driving or in a vehicle at the time of the accident?(List) : NO

Did something or someone contribute to your injury/accident?(List) : YES

ADDITIONAL INFORMATION:

ThirdParty : Lawsuit or other claim filed against a third party(List) : NO

CAUSALITY REVIEW STATUS : Open

REFERRED TO RECOVERY SPECIALIST : No

03/29/2019 04:43:04 p.m. ET Marie Chouest Nurse Sacramento TELEPHONIC
Statement: Employee Type Of Intake: Phone

MEDICAL CONDITIONS: fractured maxilla/concussion

History of Medical Condition: EE was riding her bike to work and was hit by another biker and fell fracturing and
maxilla and sustained a concussion. ERTW date is unknown.

Current Symptoms: dizziness, fatigue, brain fogginess, light sensitivity

Comorbidity: hypothyroidism, depression

Current Medications: sllep supplements

JOB FUNCTIONS:

Report: E401773R
Office: Minneapolis Claim Office
Date Of Report: 08/26/2022

The Hartford - Benefit Management Services

Page 27

Comments: Summary Detail Report

Date Range: 03/29/2019 - 02/02/2022

For business Role: Examiner

Claimant: Jennifer Mueller Insured Id : 9005440032 Claim Event Id: 16465740

Case: Northwest Permanente, P.C.

Claim Owner: Chryse Hausenfluck Role: Examiner Office: Minneapolis

Functional Requirements: walking, standing, bending,

EMPLOYMENT DETAILS:

HR Contact Name/Phone Number:

Pay Type: salary

Hours Worked: 40

Days Worked: Mon -Fri - Thurs off

Shift Details: 8:00am - 5:00pm

EXPLAIN GAP (Date Last Worked to Date of Disability): EE was not scheduled to work on March 17

ADDITIONAL INFO: Kaiser Med rec# 73745976 - Twallaton office



April 2, 2019

Jennifer E. Mueller
4404 Sw Carson St
Portland, OR 972193537

Plan Sponsor: Northwest Permanente, P.C.
Claimant: Jennifer E. Mueller
Insured ID: 9005440032
Plan Number: GRH 072800

Dear Ms. Mueller:

This letter is to inform you that Direct Deposit was set up for you to receive your Short Term Disability benefit. If you did not authorize this please contact us as soon as possible.

If you have any questions, please call Customer Service at 800-549-6514. Our hours are Monday through Friday, between 6:00 AM - 6:00 PM PST.

Sincerely,

Jennifer Bergeson

Jennifer Bergeson, Senior Ability Analyst
Hartford Life and Accident Insurance Co.
Administrator of the Short Term Disability plan for
Northwest Permanente, P.C.

Benefit Management Services
Sacramento Disability Claim Office
The Hartford
P.O. Box 14302
Lexington, KY 40512-4302
800-549-6514
Fax (866) 411-5613
STD AR 000028

Subject: [External] - FW: The file "JMueller Combined ROI--9005440032.zip" has been downloaded by permit (Encrypted Delivery)
From: Shallu.Kakkar@thehartford.com
To: GBInformationUpload (Claims Solutions and Analytics)
<GBInformationUpload@thehartford.com>

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From: noreplymft@thehartford.com <noreplymft@thehartford.com>
Sent: Friday, January 14, 2022 4:33 PM
To: Kakkar, Shallu (Claims Solutions and Analytics)
<Shallu.Kakkar@thehartford.com>
Subject: The file "JMueller Combined ROI--9005440032.zip" has been downloaded by permit

The file "JMueller Combined ROI--9005440032.zip" has been downloaded by using a permit issued to "madamezola@gmail.com
<mailto:madamezola@gmail.com>".

File:

JMueller Combined ROI--9005440032.zip

Permit creator:

SK00319

Permit recipient:

madamezola@gmail.com <mailto:madamezola@gmail.com>

Folder:

/My Files/Outgoing/JMueller Combined ROI--9005440032.zip

Expiration date:

STD AR 000029

2022-01-21 08:58:58 AM EST

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1 of 1 download(s) used

Link:

<https://mft.thehartford.com/portal-seeefx/app/?my-files=Outgoing/JMueller3>

鮑曉邏-9005440032.zip

<<https://nam12.safelinks.protection.outlook.com/?url=https%3A%2F%2Fmft.thehartford.com%2Fportal-seeefx%2Fapp%2F%3Fmy-files%3DOutgoing%2FJMueller%2BCombined%2BROI--9005440032.zip&data=04%7C01%7CGBDEdmProd%40conduent.com%7C4c2f29479fcb4d6cf7f708d9dab42ccc%7C1aed4588b8ce43a8a775989538fd30d8%7C0%7C0%7C637781290373821227%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJB>
TiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=obt9Y7ZaIL4naDN44aOy0N4UGGWQF4b0G
uKR2e%2FjtPo%3D&reserved=0>

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STD AR 000030

Subject: FW: Jennifer Mueller - 9005440032 [CONFIDENTIAL]
From: informationupload@thehartford.com
To: shared.eligib@hartfordlife.com

From: Hausenfluck, Chryse (GB and WC Claims)
Sent: Tuesday, March 3, 2020 6:03:11 PM (UTC-05:00) Eastern Time (US & Canada)
To: informationupload (GB and WC Claims)
Subject: FW: Jennifer Mueller - 9005440032 [CONFIDENTIAL]

Chryse Hausenfluck
Short Term Disability Analyst
Group Benefits Operation

<<http://www.thehartford.com/>>

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If you are submitting information for a claim, please email it to <mailto:informationupload@thehartford.com> informationupload@thehartford.com or fax it to 866-411-5613. Please be sure to include the claimant's name and insured ID number on your correspondence.

From: Tammy Kilmer [mailto:Tamison.A.Kilmer@kp.org]
Sent: Tuesday, March 03, 2020 2:55 PM
To: Hausenfluck, Chryse (GB and WC Claims)
<Chryse.Hausenfluck@thehartford.com>
Subject: RE: Jennifer Mueller - 9005440032

Hi Chryse,

It looks like we had provided Jennifer Soyke's information in error of Jennifer Mueller. I have attached Jennifer Mueller's calculation.

Also, I had a discussion with her today. She wanted to know if her LTD is approved and her FTE changes officially from a .9 to a .5 would she lose the LTD benefit since she goes permanently part time?

Thank you,

Tammy Kilmer ("she/her")

Senior Benefit Analyst

Human Resources

Permanente Medicine

Northwest Permanente, PC

500 NE Multnomah Street, Ste. 100, 15th Floor

Portland, OR 97232-2023

503-813-2235 (office)

49-2235 (tie-line)

503-813-4412 (Benefit Department Group Line)

49-4412 (Benefit Department Group tie-line)

Fax: 503-813-2395

Email: NWP-BenefitsTeam@kp.org <mailto:NWP-BenefitsTeam@kp.org>

Email: tamison.a.kilmer@kp.org <mailto:May.y.lee@kp.org>

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From: Tammy Kilmer
Sent: Thursday, February 13, 2020 9:20 AM
To: Hausenfluck, Chryse (GB and WC Claims)
<Chryse.Hausenfluck@thehartford.com
<mailto:Chryse.Hausenfluck@thehartford.com> >
Subject: RE: Jennifer Mueller - 9005440032

Hi Chryse,

That is correct.

Thank you,

Tammy Kilmer ("she/her")

Senior Benefit Analyst

Human Resources

Permanente Medicine

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Email: NWP-BenefitsTeam@kp.org <mailto:NWP-BenefitsTeam@kp.org>

Email: tamison.a.kilmer@kp.org <mailto:May.y.lee@kp.org>

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From: Hausenfluck, Chryse (GB and WC Claims)
<Chryse.Hausenfluck@thehartford.com
<mailto:Chryse.Hausenfluck@thehartford.com> >
Sent: Monday, February 10, 2020 12:26 PM
To: Tammy Kilmer <Tamison.A.Kilmer@kp.org
<mailto:Tamison.A.Kilmer@kp.org> >
Subject: RE: Jennifer Mueller - 9005440032

Good afternoon,

I had the chance to review the pay you sent over for Jennifer. If I am reading it correctly she received her full from 8/11/19 through 9/21/19 with the combination of her worked hours and sick time?

Thank you,

Chryse Hausenfluck
Short Term Disability Analyst
Group Benefits Operation

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Lexington, KY 40512-4302](https://urldefense.com/v3/__http://www.thehartford.com/__;!!BZ50a36bapWJ!45SDD6RutOXSzpbPlQF9qTygWSWjer6XH_4fcFX4GYClosaeCKxQYpPiepkOOMxXVGE$></p></div><div data-bbox=)

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From: Tammy Kilmer [mailto:Tamison.A.Kilmer@kp.org]
Sent: Wednesday, February 05, 2020 9:14 AM
To: Hausenfluck, Chryse (GB and WC Claims)
<Chryse.Hausenfluck@thehartford.com
<mailto:Chryse.Hausenfluck@thehartford.com> >
Subject: RE: Jennifer Mueller - 9005440032 [CONFIDENTIAL]

Hi Chryse,

Here you go.

Thank you,

Tammy Kilmer ("she/her")

Senior Benefit Analyst

Human Resources

Permanente Medicine

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From: Hausenfluck, Chryse (GB and WC Claims)
<Chryse.Hausenfluck@thehartford.com
<mailto:Chryse.Hausenfluck@thehartford.com> >
Sent: Tuesday, February 4, 2020 3:13 PM
To: Tammy Kilmer <Tamison.A.Kilmer@kp.org
<mailto:Tamison.A.Kilmer@kp.org> >
Subject: Jennifer Mueller - 9005440032 [CONFIDENTIAL]

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Good afternoon,

Can you please fill out the attached template for Jennifer covering 8/12/19 through 9/15/19 for her part time work?

Thank you,

Chryse Hausenfluck
Short Term Disability Analyst
Group Benefits Operation

STD AR 000037

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Plan Provisions

Current Weekly Earnings means weekly earnings You receive from:

- 1) Your Employer; and
- 2) any other work for pay or profit;

while You are Disabled and eligible for the Disabled and Working Benefit. Current Weekly Earnings will include Commissions and will be pro-rated as necessary.

Disabled and Working means that You are prevented by:

- 1) Injury;
- 2) Sickness;
- 3) Mental Illness;
- 4) Substance Abuse; or
- 5) pregnancy

from performing some, but not all of the Essential Duties of Your Occupation, are working on a part-time basis, and as a result, Your Current Weekly Earnings are more than 20%, but are less than or equal to 80% of Your Pre-disability Earnings.

Pre-disability Earnings means Your regular weekly rate of pay from Your Employer, not counting Bonuses or Commissions, in effect during the last full calendar month that You were Actively at Work before You became Disabled. Pre-disability Earnings does not include any other fringe benefits or extra compensation. In addition, earnings for overtime or on-call hours are not included unless regularly scheduled.

However, if You are an hourly paid Employee, Pre-disability Earnings means the product of:

- 1) the average number of hours You worked per week, including hours from paid vacation, sick time, overtime, or regularly scheduled) and other paid time off, not including on-call hours, over the most recent 12 months immediately prior to the last day You were Actively at Work before You became Disabled, multiplied by;
- 2) Your hourly wage in effect on the last day You were Actively at Work before You became Disabled.

Pre-disability Earnings includes contributions You make through a salary reduction agreement with the Employer:

- 1) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
- 2) an executive non-qualified deferred compensation arrangement; or
- 3) a salary reduction arrangement under an IRC Section 125 plan, for the same period as above.

Disabled and Working Benefits: How are benefits paid when I am Disabled and Working?

If, while covered under this benefit, You are Disabled and Working, as defined, the following calculation will determine Your Weekly Benefit:

- 1) multiply Your Pre-disability Earnings by the Benefit Percentage; and
- 2) compare the result with the Maximum Benefit; and
- 3) from the lesser amount deduct Other Income Benefits.

Your Current Weekly Earnings will not be used to reduce Your Weekly Benefit. However, if the sum of Your Weekly Benefit and Your Current Weekly Earnings exceeds 100% of Your Pre-disability Earnings, the Employer will reduce Your Weekly Benefit by the amount of the excess.

Days which You are Disabled and Working may be used to satisfy the Benefits Commence Period.

include Bonuses

e or limited duty
10% of Your Predisability

uses and
became Disabled.
earnings from

vertime (if
any period
:

Employer to:

will be used to

Weekly Benefit and
your Weekly

Name:

Jennifer Mueller

Date of Disability:

Benefit Effective Date:

Date III Bank (sick pay) Expired:

Date of Partial Return to Work:

Date of Full Return to Work:

Documentation of Earnings Received after III Bank Expiration

Pay Period	Number of hours worked	Gross Pay
8/11/2019 - 8/24/2019	72 hours (23.5 bereavement, 4 hours sick, 15.5 hours)	\$7,683.65
8/25/2019 - 9/7/2020	72 hours (4 hours sick, 16 hours vacation)	\$7,683.65
9/8/2019 - 9/21/2019	72 hours (11.5 unpaid, 8.5 hours vacation)	\$6,323.41

**Vacation time is subtracted if earned prior to the Date of Disability*

less Vacation*	Calculated Earnings
	\$7,683.65
	\$7,683.65
	\$6,323.41
	\$0.00
	\$0.00
	\$0.00
	\$0.00
	\$0.00

Name:
Class:
Benefit %
Pay Basis:

Pre Disability Earnings:
Weekly Benefit Amount:

For the pay period 8/11/2019 - 8/24/2019
Total Days in pay period 14
Weekly Earnings:
Percentage: #DIV/0!
Weekly Benefit + CWE: \$0.00
Weekly Offset is the Excess: \$0.00

Subject: FW: Jennifer Mueller - 9005440032 [CONFIDENTIAL]
From: informationupload@thehartford.com
To: shared.eligib@hartfordlife.com

From: Hausenfluck, Chryse (GB and WC Claims)
Sent: Tuesday, March 3, 2020 6:03:11 PM (UTC-05:00) Eastern Time (US & Canada)
To: informationupload (GB and WC Claims)
Subject: FW: Jennifer Mueller - 9005440032 [CONFIDENTIAL]

Chryse Hausenfluck
Short Term Disability Analyst
Group Benefits Operation

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Subject: FW: Jennifer Mueller - 9005440032 [CONFIDENTIAL]
From: informationupload@thehartford.com
To: shared.eligib@hartfordlife.com

From: Hausenfluck, Chryse (GB and WC Claims)
Sent: Wednesday, February 5, 2020 11:15:41 AM (UTC-05:00) Eastern Time (US & Canada)
To: informationupload (GB and WC Claims)
Subject: FW: Jennifer Mueller - 9005440032 [CONFIDENTIAL]

Chryse Hausenfluck
Short Term Disability Analyst
Group Benefits Operation

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From: Tammy Kilmer [mailto:Tamison.A.Kilmer@kp.org]
Sent: Wednesday, February 05, 2020 9:14 AM
To: Hausenfluck, Chryse (GB and WC Claims)
<Chryse.Hausenfluck@thehartford.com>
Subject: RE: Jennifer Mueller - 9005440032 [CONFIDENTIAL]

Hi Chryse,

Here you go.

Thank you,

Tammy Kilmer ("she/her")
Senior Benefit Analyst
Human Resources

Permanente Medicine
Northwest Permanente, PC
500 NE Multnomah Street, Ste. 100, 15th Floor
Portland, OR 97232-2023

503-813-2235 (office)
49-2235 (tie-line)
503-813-4412 (Benefit Department Group Line)
49-4412 (Benefit Department Group tie-line)

Fax: 503-813-2395

Email: NWP-BenefitsTeam@kp.org <mailto:NWP-BenefitsTeam@kp.org>

Email: tamison.a.kilmer@kp.org <mailto:May.y.lee@kp.org>

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From: Hausenfluck, Chryse (GB and WC Claims)
<Chryse.Hausenfluck@thehartford.com
<mailto:Chryse.Hausenfluck@thehartford.com> >
Sent: Tuesday, February 4, 2020 3:13 PM
To: Tammy Kilmer <Tamison.A.Kilmer@kp.org
<mailto:Tamison.A.Kilmer@kp.org> >
Subject: Jennifer Mueller - 9005440032 [CONFIDENTIAL]

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Good afternoon,

Can you please fill out the attached template for Jennifer covering 8/12/19 through 9/15/19 for her part time work?

Thank you,

Chryse Hausenfluck
Short Term Disability Analyst
Group Benefits Operation

STD AR 000048

<https://urldefense.com/v3/__http://www.thehartford.com/__;!!BZ50a36bapWJ!
-OjwuJHR5ok9Sm7E57XXlgyYhFx8MmUFA5YhWZAnKFfw4ggX_dZeGjEVnk2moVeYSqM\$>

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-OjwuJHR5ok9Sm7E57XXlgyYhFx8MmUFA5YhWZAnKFfw4ggX_dZeGjEVnk2moVeYSqM\$>
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OjwuJHR5ok9Sm7E57XXlgyYhFx8MmUFA5YhWZAnKFfw4ggX_dZeGjEVnk2m4CkKy-M\$>
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OjwuJHR5ok9Sm7E57XXlgyYhFx8MmUFA5YhWZAnKFfw4ggX_dZeGjEVnk2mDW3pWoY\$>
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Plan Provisions

Current Weekly Earnings means weekly earnings You receive from:

- 1) Your Employer; and
- 2) any other work for pay or profit;

while You are Disabled and eligible for the Disabled and Working Benefit. Current Weekly Earnings will include Commissions and will be pro-rated as necessary.

Disabled and Working means that You are prevented by:

- 1) Injury;
- 2) Sickness;
- 3) Mental Illness;
- 4) Substance Abuse; or
- 5) pregnancy

from performing some, but not all of the Essential Duties of Your Occupation, are working on a part-time basis, and as a result, Your Current Weekly Earnings are more than 20%, but are less than or equal to 80% of Your Pre-disability Earnings.

Pre-disability Earnings means Your regular weekly rate of pay from Your Employer, not counting Bonuses or Commissions, in effect during the last full calendar month that You were Actively at Work before You became Disabled. Pre-disability Earnings does not include any other fringe benefits or extra compensation. In addition, overtime or on-call hours are not included unless regularly scheduled.

However, if You are an hourly paid Employee, Pre-disability Earnings means the product of:

- 1) the average number of hours You worked per week, including hours from paid vacation, sick time, overtime (if regularly scheduled) and other paid time off, not including on-call hours, over the most recent 12 months immediately prior to the last day You were Actively at Work before You became Disabled, multiplied by;
- 2) Your hourly wage in effect on the last day You were Actively at Work before You became Disabled.

Pre-disability Earnings includes contributions You make through a salary reduction agreement with the Employer:

- 1) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
- 2) an executive non-qualified deferred compensation arrangement; or
- 3) a salary reduction arrangement under an IRC Section 125 plan, for the same period as above.

Disabled and Working Benefits: How are benefits paid when I am Disabled and Working?

If, while covered under this benefit, You are Disabled and Working, as defined, the following calculation will determine Your Weekly Benefit:

- 1) multiply Your Pre-disability Earnings by the Benefit Percentage; and
- 2) compare the result with the Maximum Benefit; and
- 3) from the lesser amount deduct Other Income Benefits.

Current Weekly Earnings will not be used to reduce Your Weekly Benefit. However, if the sum of Your Current Weekly Earnings exceeds 100% of Your Pre-disability Earnings, the Employer will reduce Your Weekly Benefit by the amount of the excess.

Days which You are Disabled and Working may be used to satisfy the Benefits Commence Period.

include Bonuses

e or limited duty
% of Your Predisability

uses and
became Disabled.
arnings from

vertime (if
period
:

Employer to:

will be used to

Weekly Benefit and
our Weekly

Name:
Class:
Benefit %
Pay Basis:

Pre Disability Earnings:
Weekly Benefit Amount:

For the pay period 8/11/2019 - 8/24/2019
Total Days in pay period 14
Weekly Earnings:
Percentage: #DIV/0!
Weekly Benefit + CWE: \$0.00
Weekly Offset is the Excess: \$0.00

Name: Jennifer Soyke

Date of Disability:

Benefit Effective Date:

Date III Bank (sick pay) Expired:

Date of Partial Return to Work:

Date of Full Return to Work:

Documentation of Earnings Received after III Bank Expiration

Pay Period	Number of hours worked	Gross Pay	less Vacation*	Calculated Earnings
8/11/2019 - 8/24/2019	40 hours (32 hours sick)	\$7,556.42		\$7,556.42
8/25/2019 - 9/7/2020	0 (72 hours sick)	\$7,983.92		\$7,983.92
9/8/2019 - 9/21/2019	30 hours (42 hours sick)	\$7,257.17		\$7,257.17
				\$0.00
				\$0.00
				\$0.00
				\$0.00
				\$0.00

**Vacation time is subtracted if earned prior to the Date of Disability*

Subject: FW: Jennifer Mueller - 9005440032 [CONFIDENTIAL]
From: informationupload@thehartford.com
To: shared.eligib@hartfordlife.com

From: Hausenfluck, Chryse (GB and WC Claims)
Sent: Wednesday, February 5, 2020 11:15:41 AM (UTC-05:00) Eastern Time (US & Canada)
To: informationupload (GB and WC Claims)
Subject: FW: Jennifer Mueller - 9005440032 [CONFIDENTIAL]

Chryse Hausenfluck
Short Term Disability Analyst
Group Benefits Operation

<<http://www.thehartford.com/>>

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Current		YTD	
Medical	Federal Income Tax	M 3	
	OR State Income Tax	M 3	
	(Residence)		
	OR State Income Tax (Work)	M 3	
Pay Statement			
Period Start Date 08/25/2019			
Period End Date 09/07/2019			
Pay Date 09/13/2019			
Document 157408			
Net Pay \$5,121.50			

Employer		
YTD	Current	YTD
\$0.00	\$0.00	\$10.45
\$0.00	\$0.00	\$788.88
\$0.00	\$0.00	\$41.61
\$0.00	\$0.00	\$1,256.28
\$16,577.69	\$872.51	\$903.26
\$2,743.20	\$151.89	\$0.00
\$32.87	\$1.73	\$0.00
\$8.74	\$0.46	\$0.00
\$12,344.46	\$683.51	\$0.00
\$197.22	\$10.38	\$0.00
\$1,428.61	\$75.19	\$0.00
\$524.40	\$27.60	\$0.00
\$31.35	\$1.65	\$0.00

Current		YTD	
Medical	Federal Income Tax	M 3	
	OR State Income Tax	M 3	
	(Residence)		
	OR State Income Tax (Work)	M 3	
Pay Statement			
Period Start Date 08/25/2019			
Period End Date 09/07/2019			
Pay Date 09/13/2019			
Document 157408			
Net Pay \$5,121.50			

Subject: FW: Jennifer Mueller-9005440032 [CONFIDENTIAL]
From: informationupload@thehartford.com
To: shared.eligib@hartfordlife.com

From: Hausenfluck, Chryse (GB and WC Claims)
Sent: Friday, September 20, 2019 3:54:13 PM (UTC-05:00) Eastern Time (US & Canada)
To: informationupload (GB and WC Claims)
Subject: FW: Jennifer Mueller-9005440032 [CONFIDENTIAL]

Chryse Hausenfluck
Short Term Disability Analyst
Group Benefits Operation

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From: Jenna G Larsen [mailto:Jenna.G.Larsen@kp.org]
Sent: Wednesday, September 18, 2019 1:05 PM
To: Hausenfluck, Chryse (GB and WC Claims)
<Chryse.Hausenfluck@thehartford.com>
Subject: RE: Jennifer Mueller-9005440032 [CONFIDENTIAL]

Hi,

\$418.04 per day

From: Hausenfluck, Chryse (GB and WC Claims)
<Chryse.Hausenfluck@thehartford.com
<mailto:Chryse.Hausenfluck@thehartford.com> >
Sent: Wednesday, September 18, 2019 12:57 PM
To: Jenna G Larsen <Jenna.G.Larsen@kp.org <mailto:Jenna.G.Larsen@kp.org>
>
Subject: RE: Jennifer Mueller-9005440032 [CONFIDENTIAL]

Thank you,

On the days she worked 4 hours at salary, how much did she make?

Chryse Hausenfluck
Short Term Disability Analyst
Group Benefits Operation

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[www.twitter.com/thehartford](https://urldefense.proofpoint.com/v2/url?u=http-3A__www.twitter.com_thehartford&d=DwMFAG&c=V-WiB07a9ZG9AUogGPqIYBXfVnjryhYX1W_SjITv1Oo&r=U2PyorWD58Sg6XNw8ydP_cJ6UQYD6PCFo63idchA0Ok&m=p3sH3lTWqVnU7tld7FFAn0P-Ypx7c1P_XsXn0em0V7Y&s=C54vy05bbEWLdGzP9CyGGqk-cm0zLRP-Ez7RkTyZs5Q&e=>)

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Sent: Wednesday, September 18, 2019 12:53 PM
To: Hausenfluck, Chryse (GB and WC Claims)
<Chryse.Hausenfluck@thehartford.com>
<<mailto:Chryse.Hausenfluck@thehartford.com>> >
Subject: RE: Jennifer Mueller-9005440032 [CONFIDENTIAL]

8/12-9/15?

8/12-4 salary

8/13 4 salary

8/14 4 salary

8/15 4 salary

8/16-0

8/17-0

8/18-0

8/19-0

8/20-0

8/21-0

8/22-0

8/23-0

8/24-0

8/25- 0

8/26- 4 salary

8/27-4 salary

8/29-4 salary

8/30-4 salary

8/31-0

9/1-4

9/2-4

9/5-4

9/6-4

9/7-0

9-8-9/15= I'll be able to provide on Monday when we process payroll for 9/8-9/20 dates

From: Hausenfluck, Chryse (GB and WC Claims)
<Chryse.Hausenfluck@thehartford.com
<mailto:Chryse.Hausenfluck@thehartford.com> >
Sent: Wednesday, September 18, 2019 12:46 PM
To: Jenna G Larsen <Jenna.G.Larsen@kp.org <mailto:Jenna.G.Larsen@kp.org>
>
Subject: RE: Jennifer Mueller-9005440032 [CONFIDENTIAL]

Thank you! When I spoke with her last she mentioned she is still working part time. Can you please send me her hours from 8/12-9/15?

Thank you,

Chryse Hausenfluck
Short Term Disability Analyst
Group Benefits Operation

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<https://urldefense.proofpoint.com/v2/url?u=http-3A__www.facebook.com_thehartford_d=DwMFAG&c=V-WiB07a9ZG9AUogGPqIYBXfVnjryhYX1W_SjITv1Oo&r=U2PyorWD58Sg6XNw8ydP_cJ6UQYD6PCFo63idchA0Ok&m=rSr2oag1WjsL-

STD AR 000063

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<https://urldefense.proofpoint.com/v2/url?u=http-
3A_www.twitter.com_thehartford&d=DwMFAG&c=V-
WiB07a9ZG9AUogGPqIYBXfVnjryhYX1W_SjITv1Oo&r=U2PyorWD58Sg6XNw8ydP_cJ6UQYD6
PCFo63idchA00k&m=rSr2oag1WjsL-JANLigoLeaQ0Pcvg5OQNflQcQUgG5U&s=vIg-
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From: Jenna G Larsen [mailto:Jenna.G.Larsen@kp.org]
Sent: Wednesday, September 18, 2019 12:44 PM
To: Hausenfluck, Chryse (GB and WC Claims)
<Chryse.Hausenfluck@thehartford.com
<mailto:Chryse.Hausenfluck@thehartford.com> >; Ashley R Koski
<Ashley.R.Koski@kp.org <mailto:Ashley.R.Koski@kp.org> >
Subject: RE: Jennifer Mueller-9005440032

Hi,

Here is here last paycheck from September.

Thanks,

Jenna

STD AR 000064

From: Hausenfluck, Chryse (GB and WC Claims)
<Chryse.Hausenfluck@thehartford.com
<mailto:Chryse.Hausenfluck@thehartford.com> >
Sent: Wednesday, September 18, 2019 11:47 AM
To: Jenna G Larsen <Jenna.G.Larsen@kp.org <mailto:Jenna.G.Larsen@kp.org>
>; Ashley R Koski <Ashley.R.Koski@kp.org <mailto:Ashley.R.Koski@kp.org> >
Subject: Jennifer Mueller-9005440032

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Good afternoon,

I received the medical update from Dr. Mueller's doctor and am ready to issue her a check for her part time work. Before I do so, can you please advise if/when she hit the FICA threshold? I don't want to withhold extra taxes from her check if I don't have to.

Thank you,

Chryse Hausenfluck
Short Term Disability Analyst
Group Benefits Operation

<https://urldefense.proofpoint.com/v2/url?u=http-3A__www.thehartford.com_&d=DwMFAG&c=V-WiB07a9ZG9AUogGPqIYBXfVnjryhYX1W_SjITv1Oo&r=U2PyorWD58Sg6XNw8ydP_cJ6UQYD6PCFo63idchA0Ok&m=iL8kcRkNC_0A6pvfpGfEZwzzEvrSmBiN7lvBVzsikwo&s=qZh8kkb4P8AbOF6EEK68O0RzNGBUuXRxhtcOGpJ8sjw&e=>>

The Hartford Financial Services Group, Inc.
PO Box 14302
Lexington, KY 40512-4302

W: (800) 549-6514 ext. 2303794
F: (866) 411-5613

<https://urldefense.proofpoint.com/v2/url?u=http-3A__www.thehartford.com_&d=DwMFAG&c=V-WiB07a9ZG9AUogGPqIYBXfVnjryhYX1W_SjITv1Oo&r=U2PyorWD58Sg6XNw8ydP_cJ6UQYD6>

STD AR 000065

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Business Insurance
Employee Benefits
Auto
Home

Subject: FW: Jennifer Mueller-9005440032 [CONFIDENTIAL]
From: informationupload@thehartford.com
To: shared.eligib@hartfordlife.com

From: Hausenfluck, Chryse (GB and WC Claims)
Sent: Friday, September 20, 2019 3:54:13 PM (UTC-05:00) Eastern Time (US & Canada)
To: informationupload (GB and WC Claims)
Subject: FW: Jennifer Mueller-9005440032 [CONFIDENTIAL]

Chryse Hausenfluck
Short Term Disability Analyst
Group Benefits Operation

<<http://www.thehartford.com/>>

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Subject: FW: Contact information- 9005440032 [CONFIDENTIAL]
From: informationupload@thehartford.com
To: shared.eligib@hartfordlife.com

From: Hausenfluck, Chryse (GB and WC Claims)
Sent: Wednesday, September 18, 2019 3:42:02 PM (UTC-05:00) Eastern Time (US & Canada)
To: informationupload (GB and WC Claims)
Subject: FW: Contact information- 9005440032 [CONFIDENTIAL]

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From: Jennifer Mueller [mailto:madamezola@gmail.com]
Sent: Wednesday, September 18, 2019 12:28 PM
To: Hausenfluck, Chryse (GB and WC Claims)
<Chryse.Hausenfluck@thehartford.com>
Subject: Re: Contact information- 9005440032

Hi Chryse,

I've attached screenshots. Let me know if you can't read them and I'll fax them over for you.

Jennifer

Sent from my iPhone, so there's probably a bunch of typos and grammatical errors.

On Sep 18, 2019, at 12:06 PM, Hausenfluck, Chryse (GB and WC Claims) <Chryse.Hausenfluck@thehartford.com>
<mailto:Chryse.Hausenfluck@thehartford.com> > wrote:

Good afternoon,

Thank you for taking my call this afternoon. If you are able to access your most recent paystub, please email me a copy.

Thank you,

Chryse Hausenfluck
Short Term Disability Analyst

STD AR 000071

Group Benefits Operation

<<http://www.thehartford.com/>> <image001.png>

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Business Insurance
Employee Benefits
Auto
Home

Current		YTD	
Medical	Federal Income Tax	M 3	
	OR State Income Tax	M 3	
	(Residence)		
	OR State Income Tax (Work)	M 3	
Pay Statement			
Period Start Date 08/25/2019			
Period End Date 09/07/2019			
Pay Date 09/13/2019			
Document 157408			
Net Pay \$5,121.50			

Employer		
YTD	Current	YTD
\$0.00	\$10.45	\$788.88
\$0.00	\$0.00	\$41.61
\$0.00	\$0.00	\$1,256.28
\$16,577.69	\$872.51	\$903.26
\$2,743.20	\$151.89	\$0.00
\$32.87	\$1.73	\$0.00
\$8.74	\$0.46	\$0.00
\$12,344.46	\$683.51	\$0.00
\$197.22	\$10.38	\$0.00
\$1,428.61	\$75.19	\$0.00
\$524.40	\$27.60	\$0.00
\$31.35	\$1.65	\$0.00

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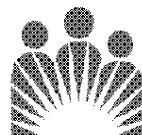
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TIME RECEIVED	REMOTE CSID	DURATION	PAGES	STATUS
September 16, 2019 10:49:05 AM EDT	KPRFN001	192	4	Received
KPRFN001	9/16/2019 7:45:54 AM	PAGE 1/004	Fax Server	



KAISER PERMANENTE®

To: The Hartford
Company:
Fax: 918664115613
Phone:

From: Martin R McCray ROIS
Fax: 503-571-2624
Phone: 503-571-5051
E-mail: Martin.R.Mccray@kp.org

Subject:



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STD-AR-000078

08-30-19

7374-59-76

Please fax the completed form to:

Fax Number: 866-411-5613

The Hartford

P.O.Box 14301

Lexington, KY 40512-4301

Email: APSupload@thehartford.com



ATTENDING PHYSICIAN'S STATEMENT - PROGRESS REPORT

To be completed by the Employee

Patient Name: JENNIFER mUELLER	Date of Birth: REDACTED	Insured ID Number:
Patient Address: (Street, City, State & Zip Code)		

To be completed by the Provider - Use current information from your patient's most recent office visit or examination to complete this form. (The patient is responsible for the completion of this form without expense to the Company.)

Medical Conditions Impacting Activity

Primary condition: <u>POSTCONCUSSION SYNDROME</u>	ICD-9 Code: <input type="checkbox"/>	ICD-10 Code: <input checked="" type="checkbox"/> F07.81
Secondary condition(s): <u>MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE</u>	ICD-9 Code: <input type="checkbox"/>	ICD-10 Code(s): <input checked="" type="checkbox"/> F33.42
Subjective symptoms: <u>Symptoms include fatigue, photophobia, headache, word finding, decreased interest in reading.</u>		

Objective Physical Findings (Please include office notes for date(s): _____ to _____)

Jennifer is being treated for light sensitivity, impaired reading and screen use, fatigue, decreased concentration and processing speed, concern for convergence insufficiency s/p concussion 3/18/19. Jennifer is making slow steady gains with improved ability to read and use computer before being limited by her symptoms. Moderate improvement with dizziness and nausea during activities. Jennifer will benefit from continued skilled OT intervention to advance visual skills, utilize compensatory strategies, being independent with HEP in order to facilitate graded return to functional activity in order to be able to resume I/ADLs without or with fewer limitations.

Pertinent Test Results (list all results or attach test results):

Test: _____	Date: _____	Results: _____
Test: _____	Date: _____	Results: _____
Condition(s) Specific Medications, Dosage and Frequency: <u>(WELLBUTRIN XL) 150 mg , DULOXETINE 30 MG</u>		

TREATMENT PLAN

Current Treatment Plan: <u>CLINICIAN SUPERVISION, PRESCRIPTION MEDS, PHYSICAL THERAPY ,</u>		
<u>REDUCED WORK HOURS OF 4 HOURS PER DAY, 5 DAYS PER WEEK STARTING 10-01-19 THRU 12-31-19</u>		
What is the Frequency / Duration of Treatment? <u>AS DIRECTED</u>	Dates of Treatment: <u>07-31-19, 05-21-19, 05-14-19, 05-08-19</u> <u>05-02-19, 04-29-19, 04-25-19, 04-17-19</u>	
First Office Visit for this condition: <u>03-18-19</u>	Last Office Visit: <u>07-31-19</u>	Next Scheduled Office Visit: <u>09-11-19</u>
Has Surgery been performed since last report: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," on what Date(s): _____		
Procedure(s): _____		CPT Code(s): _____
Was patient hospitalized since last report? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," Hospital name and Phone Number: _____		
Admission date: _____ Discharge date: _____		
Has patient been referred to other physicians? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," Date of Referral(s): _____		
Other Physician Name _____	Phone Number: () _____	Specialty: _____
Other Physician Name _____	Phone Number: () _____	Specialty: _____

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Patient Name: JENNIFER MUELLER

Date of Birth: REDACTED

Insured ID Number:

Please complete this section to the best of your ability. Generalized comments such as "unable to work" may delay your patient's disability benefits.

Based on your most recent medical findings and opinion, address the full range of restrictions/limitations, noting that we will conclude there are no restrictions on function unless specified below.

Restrictions/Limitations based on office visit dated: _____ Expected Return to Work date: _____

In an 8 hour period the patient is able to: (select either continuous or intermittent)

	Continuously with standard breaks	or	Intermittently with standard breaks	If intermittent circle time for each section below															
				Hours at one time								Total hours/8 hours							
Sit	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Stand	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Walk	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8

Provide medical findings/rationale for your opinion if patient is unable to continuously sit, stand or walk:

Activity Ability (with normal breaks)	Never 0 hours	Occasionally up to 2.5 hours	Frequently 2.5 to 5.5 hours	Constantly 5.5 to 8 hours	Please Indicate diagnosis, symptoms, exam findings, and/or imaging that supports the restrictions/limitations
Bend at waist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneel/crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lift - Indicate weight in pounds		lbs.	lbs.	lbs.	
Other Restrictions (if any)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Hand Dominance: ☐ Right ☐ Left

Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral

Fine manipulation (fingering, keyboard)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gross manipulation (grip/grasp handle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach (extend arms) above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach (extend arms) below shoulder at desk or workbench level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please attach copies of imaging results/tests

Expected duration of any restriction(s) or limitation(s) listed above: _____

Current Status (Please check one): ☐ Recovered ☐ Improved ☒ Unchanged ☐ Retrogressed

Additional Comments (If Necessary): _____

Does the patient have a psychiatric / cognitive impairment? ☐ Yes ☒ No If "Yes," please describe the extent of the impairment and its etiology: _____

In your opinion is the patient competent to endorse checks and direct the use of the proceeds? ☒ Yes ☐ No

Provider's Name: (please print or type)

KATHLEEN M LAUGHLIN, MD

EIN Number:

REDACTED

License Number:

Telephone Number:

(503) 571-5051

Fax Number:

(503) 571-2624

Degree:

MD

Specialty:

FP

Street Address (Street, City, State & Zip Code):

10220 SE SUNNYSIDE RD, CLACKAMAS, OR 97015

Office Contact and Telephone Number:

RELEASE OF INFORMATION 503-571-5051

Provider's Signature:

Date signed:

9/13/2019

201904012000261

**KAISER PERMANENTE.**

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

Authorization for Kaiser Permanente to Use/Disclose Protected Health Information

1 PATIENT Jennifer E Mueller		
NICKNAME / MAIDEN NAME / OTHER:		
HEALTH RECORD NUMBER 7374 5976		
DATE OF BIRTH (MM/DD/YYYY) 09/08	TELEPHONE NUMBER 503-217-9161	
ADDRESS STREET OR BOX NUMBER 4404 SW Carson St		
CITY Portland	STATE OR	ZIP 97219

2 I authorize Kaiser Permanente to release the following information for: verification of medical condition
qualifying for short term disability

3 NAME OF PERSON TO RECEIVE INFORMATION The Hartford			
TITLE (PHYSICIAN, ATTORNEY, ETC.) —		PHONE NO. 866-945-7801	
STREET ADDRESS		CITY	STATE ZIP

4 The purpose or need for the exchange and disclosure of this information is to:
1. Facilitate treatment; (2) Summarize treatment and/or; (3) Facilitate billing/reimbursement from insurance carriers.

5 Description of information to be used/disclosed (Be as specific as possible):
☒ All records
☐ X-ray films (describe):
☒ Other (describe): Include dental and OSHA records available through Core Everywhere
☐ Dental Only:

6 Media Type: Delivery Preference:
☒ Electronic ☐ Email/Secure Portal (Email address: _____)
☐ Paper ☐ Pickup ☐ Mail ☐ CD (Dental only)

7 If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I place my initials in the applicable space next to the type of information:

_____ Drug/Alcohol diagnosis, treatment or referral information _____ HIV/AIDS information
_____ Mental Health Information - including provider notes _____ Genetic testing information

8 I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of drug/alcohol diagnosis, treatment or referral information, mental health information and genetic testing information.

Kaiser Permanente will not condition treatment, payment, enrollment, or eligibility for benefits on providing, or refusing to provide this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

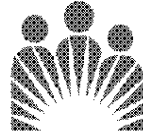
You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Kaiser Permanente, Release of Information Department at 10220 SE Sunnyside Rd., Clackamas, Oregon 97015 and state that you are revoking this authorization. To revoke this authorization orally, please call Release of Information Department at 503-571-5051 and state that you are orally revoking this authorization.

I have read this authorization and understand it. Unless revoked, this authorization expires in 12 months. In Washington, this authorization shall expire 90 days after the date signed if disclosure is to a financial institution or an employer for purposes other than payment.

A copy of this authorization is valid as an original. Member/patient has a right to a copy of this authorization.

9 X [Signature] **10** X 3/21/2019
SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE DATE
X _____
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

TIME RECEIVED	REMOTE CSID	DURATION	PAGES	STATUS
September 16, 2019 10:49:05 AM EDT	KPRFN001	192	4	Received
KPRFN001	9/16/2019 7:45:54 AM	PAGE 1/004	Fax Server	



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To: The Hartford
Company:
Fax: 918664115613
Phone:

From: Martin R McCray ROIS
Fax: 503-571-2624
Phone: 503-571-5051
E-mail: Martin.R.Mccray@kp.org

Subject:



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Sent: Monday, September 2, 2019 6:32:07 PM (UTC-05:00) Eastern Time (US & Canada)
To: informationupload (GB and WC Claims)
Subject: FW: DAW Template- Mueller 9005440032 [CONFIDENTIAL]

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If you are submitting information for a claim, please email it to <mailto:informationupload@thehartford.com> informationupload@thehartford.com or fax it to 866-411-5613. Please be sure to include the claimant's name and insured ID number on your correspondence.

From: Jenna G Larsen [mailto:Jenna.G.Larsen@kp.org]
Sent: Tuesday, August 27, 2019 8:00 AM
To: Jones, Vanessa (GB and WC Claims); Hausenfluck, Chryse (GB and WC Claims)
Subject: DAW Template- Mueller.xlsx

Hi,

Thank you for helping me look into this. Attached is the template for Mueller. If you need more information from me please let me know.

Thanks,

Jenna

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Plan Provisions

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- 4) Substance Abuse; or
- 5) pregnancy

from performing some, but not all of the Essential Duties of Your Occupation, are working on a part-time basis, and as a result, Your Current Weekly Earnings are more than 20%, but are less than or equal to 80% of Your Pre-disability Earnings.

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Days which You are Disabled and Working may be used to satisfy the Benefits Commence Period.

include Bonuses

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Employer to:

will be used to

Weekly Benefit and
our Weekly

Name: **Jennifer E Mueller**

Date of Disability: 3/18/2019
 Benefit Effective Date: 3/25/2019
 Date III Bank (sick pay) Expired: 3/22/2019
 Date of Partial Return to Work: 5/20/2019
 Date of Full Return to Work:

Documentation of Earnings Received after III Bank Expiration

Pay Period	Number of hours worked	Gross Pay	less Vacation*	Calculated Earnings
7/28-8/10	40	\$7,683.65	\$2,403.73	\$5,279.92
7/14-7/27	40	\$7,683.65	\$3,344.32	\$4,339.33
6/30-7/13	36	\$8,018.11	\$2,090.20	\$5,927.91
6/16-6/29	40	\$7,683.65	\$2,508.24	\$5,175.41
6/2-6/15	36	\$7,683.65	\$2,926.28	\$4,757.37
5/19-6/1	29	\$7,683.65	\$2,821.77	\$4,861.88
5/5-5/18	0	\$3,255.30	\$2,194.71	\$1,060.59
				\$0.00
				\$0.00
				\$0.00
				\$0.00
				\$0.00
				\$0.00

**Vacation time is subtracted if earned prior to the Date of Disability*

Name:
Class:
Benefit %
Pay Basis:

Pre Disability Earnings:
Weekly Benefit Amount:

For the pay period 7/28-8/10
Total Days in pay period 14
Weekly Earnings:
Percentage: #DIV/0!
Weekly Benefit + CWE: \$0.00
Weekly Offset is the Excess: \$0.00

Subject: FW: DAW Template- Mueller 9005440032 [CONFIDENTIAL]
From: informationupload@thehartford.com
To: shared.eligib@hartfordlife.com

From: Hausenfluck, Chryse (GB and WC Claims)
Sent: Monday, September 2, 2019 6:32:07 PM (UTC-05:00) Eastern Time (US & Canada)
To: informationupload (GB and WC Claims)
Subject: FW: DAW Template- Mueller 9005440032 [CONFIDENTIAL]

Chryse Hausenfluck
Short Term Disability Analyst
Group Benefits Operation

<<http://www.thehartford.com/>>

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Subject: FW: Jennifer Muller [CONFIDENTIAL]
From: informationupload@thehartford.com
To: shared.eligib@hartfordlife.com

From: Jones, Vanessa (GB and WC Claims)
Sent: Thursday, June 20, 2019 4:08:10 PM (UTC-05:00) Eastern Time (US & Canada)
To: informationupload (GB and WC Claims)
Cc: Bergeson, Jen (GB and WC Claims)
Subject: FW: Jennifer Muller [CONFIDENTIAL]

Insured id 9005440032

Please let me know if you need anything else to process.

Vanessa Jones

Specialist, Claim Customer Support
Commercial Markets - Group Benefit Claims

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From: Jenna G Larsen [mailto:Jenna.G.Larsen@kp.org]
Sent: Thursday, June 20, 2019 12:21 PM
To: Jones, Vanessa (GB and WC Claims)
Subject: FW: Jennifer Muller

Hi Vanessa,

Here is the updated excel chart.

Thanks,

Jenna

From: Jenna G Larsen
Sent: Monday, June 17, 2019 3:03 PM
To: Jones, Vanessa (GB and WC Claims) <vanessa.jones1@thehartford.com>
Subject: Jennifer Muller

Hi Vanessa,

I'll be able to provide the last two weeks of pay this Wednesday. Payroll is still in the middle of being processed. I do show how many hours she has worked, but the gross pay I can show on Wednesday.

Thanks,

Jenna

From: Jenna G Larsen
Sent: Monday, June 10, 2019 7:02 AM

To: Bergeson, Jen (GB and WC Claims) <Jennifer.Bergeson@thehartford.com
<mailto:Jennifer.Bergeson@thehartford.com> >
Subject: DAW Template (002).xlsx

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Employer to:

will be used to

Weekly Benefit and
our Weekly

Name: Jennifer E Mueller

Date of Disability: 5/19/2019

Benefit Effective Date:

Date III Bank (sick pay) Expired: 6/3/2018

Date of Partial Return to Work: 5/20/2019

Date of Full Return to Work:

Documentation of Earnings Received after III Bank Expiration

Pay Period	Number of hours worked	Gross Pay	less Vacation*	Calculated Earnings
6/2-6/15	44	\$7,683.65	\$2,926.28	\$4,757.37
5/19-6/1	37	\$7,683.65	\$2,403.73	\$5,279.92
5/5-5/18	8	\$3,255.30	\$1,567.65	\$1,687.65
				\$0.00
				\$0.00
				\$0.00
				\$0.00
				\$0.00
				\$0.00

**Vacation time is subtracted if earned prior to the Date of Disability*

Name:
Class:
Benefit %
Pay Basis:

Pre Disability Earnings:
Weekly Benefit Amount:

For the pay period 5/19-6/1
Total Days in pay period 14
Weekly Earnings:
Percentage: #DIV/0!
Weekly Benefit + CWE: \$0.00
Weekly Offset is the Excess: \$0.00

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From: Jones, Vanessa (GB and WC Claims)
Sent: Thursday, June 20, 2019 4:08:10 PM (UTC-05:00) Eastern Time (US & Canada)
To: informationupload (GB and WC Claims)
Cc: Bergeson, Jen (GB and WC Claims)
Subject: FW: Jennifer Muller [CONFIDENTIAL]

Insured id 9005440032

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Vanessa Jones

Specialist, Claim Customer Support
Commercial Markets - Group Benefit Claims

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From: informationupload@thehartford.com
To: shared.eligib@hartfordlife.com

From: Jones, Vanessa (GB and WC Claims)
Sent: Tuesday, June 18, 2019 4:45:13 PM (UTC-05:00) Eastern Time (US & Canada)
To: Bergeson, Jen (GB and WC Claims)
Cc: informationupload (GB and WC Claims)
Subject: FW: Jennifer Muller - 9005440032 [CONFIDENTIAL]

From: Jenna G Larsen [mailto:Jenna.G.Larsen@kp.org]
Sent: Monday, June 17, 2019 6:03 PM
To: Jones, Vanessa (GB and WC Claims)
Subject: Jennifer Muller

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Thanks,

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From: Jenna G Larsen
Sent: Monday, June 10, 2019 7:02 AM
To: Bergeson, Jen (GB and WC Claims) <Jennifer.Bergeson@thehartford.com>
Subject: DAW Template (002).xlsx

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Name: Jennifer E Mueller

Date of Disability: 5/19/2019

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				\$0.00
				\$0.00
				\$0.00
				\$0.00
				\$0.00
				\$0.00

**Vacation time is subtracted if earned prior to the Date of Disability*

Name:

Class:

Benefit %

Pay Basis:

Pre Disability Earnings:

Weekly Benefit Amount:

For the pay period 5/19-6/1

Total Days in pay period 14

Weekly Earnings:

Percentage: #DIV/0!

Weekly Benefit + CWE: \$0.00

Weekly Offset is the Excess: \$0.00

Subject: FW: Jennifer Muller - 9005440032 [CONFIDENTIAL]
From: informationupload@thehartford.com
To: shared.eligib@hartfordlife.com

From: Jones, Vanessa (GB and WC Claims)
Sent: Tuesday, June 18, 2019 4:45:13 PM (UTC-05:00) Eastern Time (US & Canada)
To: Bergeson, Jen (GB and WC Claims)
Cc: informationupload (GB and WC Claims)
Subject: FW: Jennifer Muller - 9005440032 [CONFIDENTIAL]

From: Jenna G Larsen [mailto:Jenna.G.Larsen@kp.org]
Sent: Monday, June 17, 2019 6:03 PM
To: Jones, Vanessa (GB and WC Claims)
Subject: Jennifer Muller

Hi Vanessa,

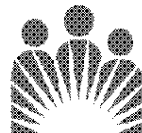
I'll be able to provide the last two weeks of pay this Wednesday. Payroll is still in the middle of being processed. I do show how many hours she has worked, but the gross pay I can show on Wednesday.

Thanks,

Jenna

From: Jenna G Larsen
Sent: Monday, June 10, 2019 7:02 AM
To: Bergeson, Jen (GB and WC Claims) <Jennifer.Bergeson@thehartford.com>
Subject: DAW Template (002).xlsx

TIME RECEIVED	REMOTE CSID	DURATION	PAGES	STATUS
May 6, 2019 4:51:49 PM EDT	KPRFC001	233	5	Received
KPRFC001	5/6/2019 1:48:02 PM	PAGE 1/005	Fax Server	



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Company: Hartford
Fax: 918664115613
Phone:

From: Brandie Sims, ROI Trainer; KPNW ROI Dept
Fax: 855-414-2792
Phone: 503-571-5083
E-mail: Brandie.M.Sims@kp.org

Subject:



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STD-AR-000105

Please fax the completed form to:

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The Hartford

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Email: APSupload@thehartford.com

HR# 7374-59-76

**ATTENDING PHYSICIAN'S STATEMENT - PROGRESS REPORT**

To be completed by the Employee

Patient Name: Jennifer Mueller	Date of Birth: REDACTED	Insured ID Number: 9005440032
Patient Address: (Street, City, State & Zip Code) 4404 SW Carson St Portland, OR 97219		

To be completed by the Provider - Use current information from your patient's most recent office visit or examination to complete this form. (The patient is responsible for the completion of this form without expense to the Company.)

Medical Conditions Impacting Activity

Primary condition: <u>Post-concussion Syndrome</u>	ICD-9 Code: <input type="checkbox"/>	ICD-10 Code: <input checked="" type="checkbox"/> F07.81
Secondary condition(s): <u>Nausea; Visual Disturbance; Cognitive Linguistic Dysfunction</u>	ICD-9 Code: <input type="checkbox"/>	ICD-10 Code(s): <input checked="" type="checkbox"/> R11.0; H53.9; R41.841
Subjective symptoms: <u>ongoing fatigue, photophobia, reduced tolerance to read or screen time and vertigo with getting up quickly or rolling over.</u>		
Objective Physical Findings (Please include office notes for date(s): _____ to _____) <u>Hallpike produces vertigo and brief nystagmus with left ear dependant</u> <u>II-12 intact to bedside exam except esophoria OD</u>		
Pertinent Test Results (list all results or attach test results): Test: _____ Date: _____ Results: _____ Test: _____ Date: _____ Results: _____		
Condition(s) Specific Medications, Dosage and Frequency: <u>Symmetrel 100 mg; Desyrel 100 mg</u>		

TREATMENT PLAN

Current Treatment Plan: <u>Clinician Supervision, Rest, Prescription Medication, PT, ST, OT, Eye Care, PHY, ENT</u>		
Unable to work 3/18 to 5/19/19, then Reduced Work hours of 4 hrs per day, 4 days per week 5/20-6/2/19		
What is the Frequency / Duration of Treatment? <u>weekly</u> Dates of Treatment: <u>4/29, 4/25, 4/18 Telephone, 4/17, 4/11</u>		
First Office Visit for this condition: <u>03/18/19</u>	Last Office Visit: <u>05/02/19</u>	Next Scheduled Office Visit: <u>05/21/19</u>
Has Surgery been performed since last report: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," on what Date(s): _____		
Procedure(s): _____ CPT Code(s): _____		
Was patient hospitalized since last report? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," Hospital name and Phone Number: _____		
Admission date: _____ Discharge date: _____		
Has patient been referred to other physicians? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," Date of Referral(s): _____		
Not anyone new since last form		
Other Physician Name _____	Phone Number: () _____	Specialty: _____
Other Physician Name _____	Phone Number: () _____	Specialty: _____

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The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

STD AR 000106

REDACTED

Patient Name: Mueller, Jennifer

Date of Birth:

Insured ID Number:

Please complete this section to the best of your ability. Generalized comments such as "unable to work" may delay your patient's disability benefits.

Based on your most recent medical findings and opinion, address the full range of restrictions/limitations, noting that we will conclude there are no restrictions on function unless specified below.

Restrictions/Limitations based on office visit dated: 05/02/19 Expected Return to Work date: 05/20/19

In an 8 hour period the patient is able to: (select either continuous or intermittent)

	Continuously with standard breaks	or	Intermittently with standard breaks	If intermittent circle time for each section below													
				Hours at one time								Total hours/8 hours					
Sit	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6
Stand	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6
Walk	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6

Provide medical findings/rationale for your opinion if patient is unable to continuously sit, stand or walk:

See DX

Activity Ability (with normal breaks)	Never 0 hours	Occasionally up to 2.5 hours	Frequently 2.5 to 5.5 hours	Constantly 5.5 to 8 hours	Please indicate diagnosis, symptoms, exam findings, and/or imaging that supports the restrictions/limitations
Bend at waist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneel/crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lift - Indicate weight in pounds		____ lbs.	____ lbs.	____ lbs.	
Other Restrictions (if any)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Hand Dominance: ☐ Right ☐ Left

Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral

Fine manipulation (fingering, keyboard)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gross manipulation (grip/grasp, handle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach (extend arms) above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach (extend arms) below shoulder at desk or workbench level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please attach copies of imaging results/tests

Expected duration of any restriction(s) or limitation(s) listed above: _____

Current Status (Please check one): ☐ Recovered ☒ Improved ☐ Unchanged ☐ Retrogressed

Additional Comments (If Necessary): May work 4 hours per day, 4 days a week from 05/20-06/2/19

Does the patient have a psychiatric / cognitive impairment? ☒ Yes ☐ No If "Yes," please describe the extent of the impairment and its etiology: Mild Cognitive Impairment

In your opinion is the patient competent to endorse checks and direct the use of the proceeds? ☐ Yes ☐ No

Provider's Name: (please print or type)

Abstracted by Brandie Sims on behalf of Kathleen M Laughlin, MD

EIN Number:

REDACTED

License Number:

MD168044

Telephone Number:

(503) 571-5051

Fax Number:

(503) 571-2624

Degree:

MD

Specialty:

FP

Street Address (Street, City, State & Zip Code):

10220 SE Sunnyside Rd Clackamas, OR 97015

Office Contact and Telephone Number:

Brandie M Sims
ROI Trainer
Date: 2019.05.06 13:46:54
-07'00'

Provider's Signature:

STD AR 000107
Date signed:



Kathleen M. Laughlin, MD
19185 Sw 90th Ave
Tualatin OR 97062
503-813-2000

Patient Name: Mueller,Jennifer E

Patient Address: 4404 SW CARSON ST
PORTLAND, OR 97219

Encounter Date: 5/6/2019

Please see below for this health care provider's directives and information relating to this encounter.

Work Status Report

Date onset of condition:

Next Appointment Date:

Reason for Off Work: Incapacitating Injury or Pain

Off Work

This patient is placed off work from 3/18/2019 through 5/19/2019

Modified Activity (Applies to work and home)

This patient is placed on modified activity at work and at home from 5/20/2019 through 6/2/2019.

If modified activity is not accommodated by the employer then this patient is considered temporarily and totally disabled from their regular work for the designated time and a separate off work order is not required.

This patient's activity is modified as follows:

Allowed to:

- Work no more than 4 hour(s) per workday.

Other needs and/or restrictions:

May work 4 hours per day, 4 days a week from 05/20/19 through 06/02/19

Full Duty:

The patient was evaluated and deemed able to return to work at full capacity on 6/3/2019

This form has been electronically signed and authorized by Kathleen M. Laughlin, MD

This form contains your private health information that you may choose to release to another party, therefore please review for accuracy.

201904012000261

**KAISER PERMANENTE**

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

Authorization for Kaiser Permanente to Use/Disclose Protected Health Information

1 PATIENT <u>Jennifer E. Mueller</u>		
NICKNAME / MADDEN NAME / OTHER: —		
HEALTH RECORD NUMBER <u>73745976</u>		
DATE OF BIRTH (MO/DAY/YR): <u>09/08/</u> REDACT	TELEPHONE NUMBER <u>503-217-1</u> REDACT	
ADDRESS STREET OR BOX NUMBER <u>4404 SW Carson St</u>		
CITY <u>Portland</u>	STATE <u>OR</u>	ZIP <u>97219</u>

2 I authorize Kaiser Permanente to release the following information for: verification of medical condition
qualifying for short term disability

3 NAME OF PERSON TO RECEIVE INFORMATION <u>The Hartford</u>			
TITLE (PHYSICIAN, ATTORNEY, ETC.): —		PHONE NO. <u>866-945-7801</u>	
STREET ADDRESS		CITY	STATE <u>OR</u>
		ZIP	

4 The purpose or need for the exchange and disclosure of this information is to:
1. Facilitate treatment; (2) Summarize treatment and/or; (3) Facilitate billing/reimbursement from insurance carriers.

5 Description of information to be used/disclosed (Be as specific as possible):
☒ All records
☐ X-ray films (describe):
☒ Other (describe): Include dental and OSHA records available through Core Everywhere
☐ Dental Only:

6 Media Type: ☒ Electronic ☐ Paper
 Delivery Preference: ☐ Email/Secure Portal (Email address:)
☐ Pickup ☐ Mail ☐ CD (Dental only)

7 If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I place my initials in the applicable space next to the type of information:

_____ Drug/Alcohol diagnosis, treatment or referral information _____ HIV/AIDS information
 _____ Mental Health Information - including provider notes _____ Genetic testing information

8 I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of drug/alcohol diagnosis, treatment or referral information, mental health information and genetic testing information.

Kaiser Permanente will not condition treatment, payment, enrollment, or eligibility for benefits on providing, or refusing to provide this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care service is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Kaiser Permanente, Release of Information Department at 10220 SE Sunnyside Rd., Clackamas, Oregon 97015 and state that you are revoking this authorization. To revoke this authorization orally, please call Release of Information Department at 503-571-5051 and state that you are orally revoking this authorization.

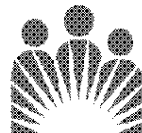
I have read this authorization and understand it. Unless revoked, this authorization expires in 12 months. In Washington, this authorization shall expire 90 days after the date signed if disclosure is to a financial institution or an employer for purposes other than payment.

A copy of this authorization is valid as an original. Member/patient has a right to a copy of this authorization.

9 X Jennifer E. Mueller
 SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE
 X
 DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

10 X 3/29/2019
 DATE

TIME RECEIVED	REMOTE CSID	DURATION	PAGES	STATUS
May 6, 2019 4:51:49 PM EDT	KPRFC001	233	5	Received
KPRFC001	5/6/2019 1:48:02 PM	PAGE 1/005	Fax Server	



KAISER PERMANENTE®

To: Hartford
Company: Hartford
Fax: 918664115613
Phone:

From: Brandie Sims, ROI Trainer; KPNW ROI Dept
Fax: 855-414-2792
Phone: 503-571-5083
E-mail: Brandie.M.Sims@kp.org

Subject:



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STD-AR-0004110

TIME RECEIVED	REMOTE CSID	DURATION	PAGES	STATUS
April 18, 2019 1:24:50 PM EDT	KPRFC003	438	12	Received
KPRFC003	4/18/2019 10:17:38 AM	PAGE 1/012	Fax Server	



KAISER PERMANENTE®

To: THE HARTFORD ATTN JEN BERGESON
Company:
Fax: 91866-411-5613
Phone:

From: Monica McGee-Stopper
Fax:
Phone:
E-mail: erin.m.kepfer@kp.org

Subject:



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STD-AR-000411

From: Bergeson, Jennifer (GB and WC Claims)
Date Sent: Thu, 04 Apr 2019 12:44:17 -07:00
To: NW.ROI@kp.org
Subject: (PHI)NWPerm MD Form [CONFIDENTIAL]
Attachments: aps_progress_report_lc-7137_10.pdf; JENNIFER E MUELLER 9005440032.pdf

Caution: This email came from outside Kaiser Permanente. Do not open attachments or click on links if you do not recognize the sender.

AUTHORIZATION ATTACHED

JENNIFER E MUELLER, DOB REDACTED Kaiser Med rec# 73745976 - Twallaton office

Please send all records from 3/18/19 through present from treating provider: DR. KATHLEEN LAUGHLIN

Please have Physician complete attached form.

PLEASE FAX BACK TO 866-411-5613 include Insured ID # 9005440032

Jen Bergeson
Sr. Ability Analyst
Short Term Disability, Group Benefits Claims
Normal Business Hours: M-F 7am to 3:30pm EST

[The Hartford]<<https://www.thehartford.com/>>

The Hartford Financial Services Group, Inc.
PO Box 14302
Lexington, KY 40512-4302

T: 800-707-5333 ext. 2308113
F 866-411-5613 (Please include Insured ID # on all correspondence)
jennifer.bergeson@thehartford.com<<mailto:jennifer.bergeson@thehartford.com>>

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201904012000261

**KAISER PERMANENTE**

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

Authorization for Kaiser Permanente to Use/Disclose Protected Health Information

1 PATIENT <u>Jennifer E. Mueller</u>		
NICKNAME / MADDEN NAME / OTHER:		
HEALTH RECORD NUMBER <u>73745976</u>		
DATE OF BIRTH (MO/DAY/YR) <u>09/08/</u>	TELEPHONE NUMBER <u>503-217-1161</u>	
ADDRESS STREET OR BOX NUMBER <u>4404 SW Carson St</u>		
CITY <u>Portland</u>	STATE <u>OR</u>	ZIP <u>97219</u>

2 I authorize Kaiser Permanente to release the following information for: verification of medical condition
qualifying for short term disability

3 NAME OF PERSON TO RECEIVE INFORMATION <u>The Hartford</u>			
TITLE (PHYSICIAN, ATTORNEY, ETC.) <u>—</u>		PHONE NO. <u>866-945-7801</u>	
STREET ADDRESS		CITY	STATE
			ZIP

4 The purpose or need for the exchange and disclosure of this information is to:
1. Facilitate treatment; (2) Summarize treatment and/or; (3) Facilitate billing/reimbursement from insurance carriers.

5 Description of information to be used/disclosed (Be as specific as possible):
☒ All records
☐ X-ray films (describe):
☒ Other (describe): Include dental and OSHA records available through Core Everywhere
☐ Dental Only:

6 Media Type: Delivery Preference:
☒ Electronic ☐ Email/Secure Portal (Email address:)
☐ Paper ☐ Pickup ☐ Mail ☐ CD (Dental only)

7 If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I place my initials in the applicable space next to the type of information:

_____ Drug/Alcohol diagnosis, treatment or referral information _____ HIV/AIDS information
 _____ Mental Health Information - including provider notes _____ Genetic testing information

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I have read this authorization and understand it. Unless revoked, this authorization expires in 12 months. In Washington, this authorization shall expire 90 days after the date signed if disclosure is to a financial institution or an employer for purposes other than payment.

A copy of this authorization is valid as an original. Member/patient has a right to a copy of this authorization.

9 X Jennifer E. Mueller
 SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE
 X
 DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

10 X 3/29/2019
 DATE



Kaiser Foundation Health Plan of the Northwest
Toll Free: (800) 813-2000

RELEASE OF INFORMATION DEPARTMENT

Telephone: (503) 571-5051 / Fax: (503) 571-2624

4/18/2019

THE HARTFORD
PO BOX 14302
LEXINGTON KY 40512-4302

RE: **JENNIFER E MUELLER [7374-59-76]**
ATTENTION

- ☐ This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- ☐ It is the policy of Kaiser Permanente to require a specific authorization for certain confidential information. This authorization was not provided, therefore some information has not been included.
- ☒ Enclosed is the patient's health information you have requested. The enclosed information is all that is releasable by law and is not for redisclosure. Sensitive information has not been included unless specifically requested and authorized.
- ☐ This information is not to be redisclosed without the express authorization of the patient.
- ☐ There are no records for this patient within the time frame you have requested.
- ☐ Patient is deceased. If you are still in need of records please re-submit your request with the proper Personal Representation paperwork.
- ☐ Information requested for third party liability claim.

STD AR 000114

KAISER PERMANENTE

REGIONAL PROCESS CENTER
10220 S E Sunnyside Rd
Clackamas OR 97015

Mueller, Jennifer E **REDACTED**
MRN: 7374-59-76, DOB: Sex: F

Office Visit

3/22/2019

Encounter Information

	Provider	Department	Encounter #	Center
3/22/2019 1:00 PM	Laughlin, Kathleen M, MD	Tua-Fp	949376557	TUA

Reason for Visit

HOSPITAL FOLLOW UP bicycle accident 3/18/19

Diagnoses

	Codes	Comments
POSTCONCUSSION SYNDROME - Primary	F07.81	
SCREENING MAMMOGRAM FOR BREAST CANCER	Z12.31	
FACIAL BONE FX, INIT	S02.92XA	
VERTIGO	R42	
RIGHT SHOULDER JOINT PAIN	M25.511	
MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, IN FULL REMISSION W SEASONAL PATTERN	F33.42	

Progress Notes

Laughlin, Kathleen M, MD at 3/22/2019 8:20 PM

Status: Signed

S> 46 yrs female here for evaluation of:

Chief Complaint

Patient presents with

- **HOSPITAL FOLLOW UP**
bicycle accident 3/18/19

Bike versus bike accident 3-18 - another bike T-boned her bike and she flew off bike landing on face the right side of body - loss of consciousness at scene, quite a bit of amnesia in the hours after the accident - transported to OHSU for further evaluation - diagnosed with concussion, right maxillary fracture, contusions. Kept overnight for observation.

Postconcussion syndrome - still very tired, notes decreased concentration. "decreased brain power" Couldn't knit easily today. Continues to have vertigo, especially movement related. Worse when rolling over in bed. Taking Meclizine regularly which seems to help with vertigo. Walking around by herself. Patient wonders about postconcussion program - we discussed that many patients have symptoms for first 6 weeks, but tend to do quite well after that point

Some headaches in the evening. Taking a fair amount of Aleve.

Right shoulder - quite bruised - one spot is quite tender to palpation but has good range of motion of right shoulder - doesn't think it's broken

Depression - patient started taking husband's Cymbalta 30 mg several weeks ago because of persistent depression - notes marked improvement in symptoms - seems to be a bit more antsy on both the Wellbutrin and Cymbalta - wants to decrease Wellbutrin to 150 mg

KAISER PERMANENTE

REGIONAL PROCESS CENTER
10220 S E Sunnyside Rd
Clackamas OR 97015

Mueller, Jennifer E
MRN: 7374-59-76, DOB: REDACTED Sex: F

Progress Notes (continued)

Laughlin, Kathleen M, MD at 3/22/2019 8:20 PM (continued)

1. How often do you have a drink containing alcohol?	2) 2 to 4 times a month
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0) 0 to 2
3. How often do you have four or more drinks on one occasion?	0) Never
4. How often during the last year have you found that you were not able to stop drinking once you had started?	0) Never
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	0) Never
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	0) Never
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	0) Never
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	0) Never
9. Have you or someone else been injured as a result of your drinking?	0) No
10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?	0) No
Record total of specific items here	2

Alcohol - drinks 1-2 drinks a few times monthly

Active Medications as of 03/22/2019:

CLINDAMYCIN HCL 150 MG ORAL CAP, Sig: Take 3 capsules by mouth every 8 hours for 4 days
CHLORHEXIDINE GLUCONATE 0.12 % MM MOUTHWASH, Sig: Take 15ml by mouth two times daily. Swish undiluted oral rinse around in mouth for 30 seconds, then spit. Do not swallow.
LEVOTHYROXINE 100 MCG ORAL TAB, Sig: Take 1 tablet by mouth 1 time a day on an empty stomach for thyroid hormone replacement
BUPROPION 300 MG (XL) ORAL 24HR SR TAB, Sig: Take 1 tablet by mouth daily

Problem List reviewed.yes

Habits:

Social History

Tobacco Use	
Smoking Status	Never Smoker
Smokeless Tobacco	Never Used

O> Young Caucasian female , no acute distress

KAISER PERMANENTE

REGIONAL PROCESS CENTER
10220 S E Sunnyside Rd
Clackamas OR 97015

Mueller, Jennifer E **REDACTED**
MRN: 7374-59-76, DOB: Sex: F

Progress Notes (continued)

Laughlin, Kathleen M, MD at 3/22/2019 8:20 PM (continued)

BP 97/72 (BP Location: LA-LEFT ARM, BP Patient Position: SITTING, Cuff Size: Standard Adult) | Pulse 88 | Temp 97.9 °F (36.6 °C) (Oral) | Resp 16 | Ht 5' 7.5" (1.715 m) | Wt 168 lb 6.4 oz (76.4 kg) | LMP 01/08/2019 | SpO2 100% | BMI 25.99 kg/m²

Exam: General appearance: alert, well appearing, and in no distress

Mental status: alert, oriented to person, place, and time

Eyes: pupils equal and reactive, extraocular eye movements intact, subconjunctival hemorrhage noted right eye

Neurological: alert, oriented, normal speech, no focal findings or movement disorder noted, screening mental status exam normal, cranial nerves II through XII intact, moves all 4 extremities equally

Musculoskeletal: abnormal exam of right shoulder/ clavicle - tenderness to palpation over right AC joint

Skin: bruised over right side of face

Psych - appropriate, articulate, no evidence of thought disorder

A/P>

(F07.81) POSTCONCUSSION SYNDROME (primary encounter diagnosis)

Comment: fatigue, vertigo, decreased concentration - already improving

Plan: REFERRAL THERAPY, SPEECH AND LANGUAGE, REFERRAL
PHYSIATRY, CHART REVIEW

We discussed that current symptoms will likely improve over next 6 weeks

(Z12.31) SCREENING MAMMOGRAM FOR BREAST CANCER

Comment: due for screening

Plan: MAMMOGRAPHY, SCREENING DIRECT DIGITAL IMAGE,
BILATERAL, ALL VIEWS

(S02.92XA) FACIAL BONE FX, INIT

Comment: minimal discomfort

Plan:gave patient copy of referral / follow up with trauma surgeon

(R42) VERTIGO

Comment: positional

Plan: REFERRAL PHYSICAL THERAPY SPECIALTY SERVICES,
REFERRAL PHYSIATRY, CHART REVIEW

Try ginger tablets / may be able to wean Meclizine (likely contributing some to fatigue)

(M25.511) RIGHT SHOULDER JOINT PAIN

Comment: suspect sprain of R AC joint

Plan: XR RIGHT CLAVICLE COMPLETE

(F33.42) MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, IN FULL REMISSION W SEASONAL PATTERN

KAISER PERMANENTE

REGIONAL PROCESS CENTER
10220 S E Sunnyside Rd
Clackamas OR 97015

Mueller, Jennifer E **REDACTED**
MRN: 7374-59-76, DOB: Sex: F

Progress Notes (continued)

Laughlin, Kathleen M, MD at 3/22/2019 8:20 PM (continued)

Comment: improved with addition of Cymbalta

Plan: DULoxetine (CYMBALTA) 30 mg Oral CPDR SR Cap

Wean Wellbutrin - alternate 150 and 300 mg every other day for 1-2 weeks, then take 150 mg daily

Call if problems

Telephone appointment or video visit in ~ 1 month

Electronically signed by Laughlin, Kathleen M, MD at 3/22/2019 8:20 PM

Nursing Notes

Ramirez, April, MA at 3/22/2019 1:12 PM

Status: Signed

Home Phone 503-217-9161

Work Phone 999-999-9999

Mobile 503-217-9161

Home Phone 218-428-0953

BP Method: dinamap

Weight: without shoes

Estimated body mass index is 25.99 kg/m² as calculated from the following:

Height as of this encounter: 5' 7.5" (1.715 m).

Weight as of this encounter: 168 lb 6.4 oz (76.4 kg).

Medications Reviewed: Yes

Patient Prefers: mail order pharmacy

Patient Support Tool Reviewed: The following care gaps have been identified: • AUDIT screening (office visit in-reach only)

• Mammogram.

Visit preparation completed, including updating Care Everywhere outside medical records.

April Ramirez, MA

Vitals

KAISER PERMANENTE

REGIONAL PROCESS CENTER
10220 S E Sunnyside Rd
Clackamas OR 97015

Mueller, Jennifer E **REDACTED**
MRN: 7374-59-76, DOB: Sex: F

Vitals (continued)

BP	Pulse	Temp	Resp	Ht
97/72 (BP Location: LA- LEFT ARM, BP Patient Position: SITTING, Cuff Size: Standard Adult)	88	97.9 °F (36.6 °C) (Oral)	16	5' 7.5" (1.715 m)

Wt	LMP	SpO2	BMI
168 lb 6.4 oz (76.4 kg)	01/08/2019	100%	25.99 kg/m²

Vitals Recorded in This Encounter

	3/22/2019 1306
BP:	97/72
Cuff Size:	Standard Adult
BP Location:	LA-LEFT ARM
Pulse:	88
Resp:	16
Temp:	97.9 °F (36.6 °C)
Temp src:	Oral
SpO2:	100 %
Weight:	168 lb 6.4 oz (76.4 kg)
Height:	5' 7.5" (1.715 m)

Medications Ordered

	Disp	Refills	Start	End
DULoxetine (CYMBALTA) 30 mg Oral CPDR SR Cap	90 capsule	PRN	3/22/2019	3/21/2020
Sig - Route: Take 1 capsule by mouth daily - Oral				

We Performed the Following

REFERRAL PHYSIATRY, CHART REVIEW
REFERRAL PHYSICAL THERAPY SPECIALTY SERVICES
REFERRAL THERAPY, SPEECH AND LANGUAGE

Encounter Messages

No messages in this encounter

KAISER PERMANENTE

REGIONAL PROCESS CENTER
10220 S E Sunnyside Rd
Clackamas OR 97015

Mueller, Jennifer E **REDACTED**
MRN: 7374-59-76, DOB: Sex: F

Video Visit 4/11/2019

Encounter Information

	Provider	Department	Encounter #	Center
4/11/2019 8:45 AM	Laughlin, Kathleen M, MD	Tua-Fp	949421855	TUA

Diagnoses

	Codes	Comments
POSTCONCUSSION SYNDROME - Primary	F07.81	

Progress Notes

Laughlin, Kathleen M, MD at 4/11/2019 9:33 AM

Status: Signed

S> 46 yrs female here for evaluation of: No chief complaint on file.

- video visit

Follow up on postconcussion syndrome - patient with improved energy over the weekend, but went to occupational therapy on Monday and had difficulty with testing and had double vision. Realizes that she is still quite fatigued and has trouble concentrating. Tried to do inbox work and didn't get much done in 2 hours.

Rare headaches, mood good - hasn't experienced depression - combination of Cymbalta and Wellbutrin working well - not as irritable

Imbalance just in the mornings briefly - then does fine during the day

No active medications on file as of 04/11/2019

Problem List reviewed.yes

Habits:

Social History

Tobacco Use	
Smoking Status	Never Smoker
Smokeless Tobacco	Never Used

O> Young Caucasian female , no acute distress
There were no vitals taken for this visit.

Exam: General appearance: alert, well appearing, and in no distress

Mental status: alert, oriented to person, place, and time

Psych - appropriate, articulate, no evidence of thought disorder

Talkative, bruising essentially gone

Two spots above right upper lip - patient says she got a couple of small rocks out of skin - will let me know if

STD AR 000120

KAISER PERMANENTE

REGIONAL PROCESS CENTER
10220 S E Sunnyside Rd
Clackamas OR 97015

Mueller, Jennifer E
MRN: 7374-59-76, DOB: **REDACTED** Sex: F

Progress Notes (continued)

Laughlin, Kathleen M, MD at 4/11/2019 9:33 AM (continued)

more come out

A/P>

(F07.81) POSTCONCUSSION SYNDROME (primary encounter diagnosis)

Comment: improving, but not ready to go back to work

Plan: see physiatry this afternoon - will discuss time frame with them

Follow up with occupational therapy - gradually increase activity

Offered support - discussed may have energy every other day / need to pace herself

Let me know if she has further foreign bodies and I will refer to plastics

Electronically signed by Laughlin, Kathleen M, MD at 4/11/2019 9:33 AM

Vitals Recorded in This Encounter

No data found in the last 1 encounters.

Medications Ordered

None

Encounter Messages

No messages in this encounter

XR RIGHT CLAVICLE COMPLETE [73000B] (Order 381077592)

Order

Status: **Final result**
(Exam End: 3/22/2019 2:12 PM)

3/24/2019 1:35 PM - Interface, Powerscribe360

Narrative

PATIENT NAME: JENNIFER E MUELLER
PATIENT MRN: 73745976

EXAM: XR RIGHT CLAVICLE COMPLETE
EXAM DATE AND TIME: 3/22/2019 2:05 PM

HISTORY: Views needed: AP AND AXIAL
CLINICAL CONCERN: recent trauma - pain over R AC joint (differential diagnosis or
r/o).

COMPARISON: None.

FINDINGS:Anatomic alignment, no evidence of fracture. AC joint looks normal.
Incidental note is made of a benign lucent focus in the proximal clavicular head.

Electronically signed by Marla K Gardner, MD. 3/24/2019 1:33 PM

Lab and Collection

STD AR 000121

KAISER PERMANENTE

REGIONAL PROCESS CENTER
10220 S E Sunnyside Rd
Clackamas OR 97015

Mueller, Jennifer E **REDACTED**
MRN: 7374-59-76, DOB: Sex: F

3/24/2019 1:35 PM - Interface, Powerscribe360 (continued)

XR RIGHT CLAVICLE COMPLETE - 3/22/2019

Result History

XR RIGHT CLAVICLE COMPLETE on 3/24/2019

END OF REPORT

TIME RECEIVED	REMOTE CSID	DURATION	PAGES	STATUS
April 18, 2019 1:24:50 PM EDT	KPRFC003	438	12	Received
KPRFC003	4/18/2019 10:17:38 AM	PAGE 1/012	Fax Server	



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To: THE HARTFORD ATTN JEN BERGESON
Company:
Fax: 91866-411-5613
Phone:

From: Monica McGee-Stopper
Fax:
Phone:
E-mail: erin.m.kepfer@kp.org

Subject:



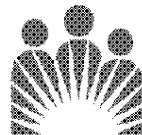
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STD-AR-000123

TIME RECEIVED	REMOTE CSID	DURATION	PAGES	STATUS
April 17, 2019 1:02:06 PM EDT	KPRFN003	181	4	Received

KPRFN003 4/17/2019 9:59:10 AM PAGE 1/004 Fax Server



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To: Hartford
Company: Hartford
Fax: 918664115613
Phone:

From: Brandie Sims, ROI Trainer; KPNW ROI Dept
Fax: 855-414-2792
Phone: 503-571-5083
E-mail: Brandie.M.Sims@kp.org

Subject:



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STD-AR-000124

Apr 04 2019 15:28:56 EDT FROM: F2M/64357417503

MSG# 1716399754-006-1

PAGE 002 OF 003

Please fax the completed form to:

Fax Number: 866-411-5613

HR# 7374-59-76

The Hartford

P.O.Box 14301

Lexington, KY 40512-4301

Email: APSupload@thehartford.com

**ATTENDING PHYSICIAN'S STATEMENT - PROGRESS REPORT****To be completed by the Employee**

Patient Name: Jennifer E Mueller	Date of Birth: REDACTED	Insured ID Number: 9005440032
Patient Address: (Street, City, State & Zip Code) 4404 SW Carson St Portland, OR 97219		

To be completed by the Provider - Use current information from your patient's most recent office visit or examination to complete this form. (The patient is responsible for the completion of this form without expense to the Company.)

Medical Conditions Impacting Activity

Primary condition: <u>Postconcussioin Syndrome</u>	ICD-9 Code: <input type="checkbox"/>	ICD-10 Code: <u>XX F07.81</u>
Secondary condition(s): <u>Insomnia; Mild Cognitive Impairment; L Peripheral Veritgo</u>	ICD-9 Code: <input type="checkbox"/>	ICD-10 Code(s): <u>XX G47.00; G31.84; H81.392</u>
Subjective symptoms: <u>ongoing fatigue, photophobia, reduced tolerance to read or screen time and vertigo with getting up quickly or rolling over. She has been unable to drive and unable to return to work</u>		
Objective Physical Findings (Please include office notes for date(s): <u>3/22/19</u> to <u>XR Right Clavicle Complete</u>		
Mild to moderate soft tissue swelling about the right cheek		
Pertinent Test Results (list all results or attach test results):		
Test: _____	Date: _____	Results: _____
Test: _____	Date: _____	Results: _____
Condition(s) Specific Medications, Dosage and Frequency: _____		

TREATMENT PLAN

Current Treatment Plan: <u>Clinician Supervision, Rest, Prescription Medication, Referral to Physical Therapy, Eye Care, Occupational Therapy, Speech and Language, Physiatry, ENT, Unable to work 3/18 to 5/5/19</u>		
What is the Frequency / Duration of Treatment? <u>as needed/directed</u> Dates of Treatment: <u>03/22,03/26,04/08/19</u>		
First Office Visit for this condition: <u>03/18/19</u>	Last Office Visit: <u>04/11/19</u>	Next Scheduled Office Visit: <u>4/17,4/18,4/25,4/29,4/30,5/2,5/21/19</u>
Has Surgery been performed since last report: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," on what Date(s): _____		
Procedure(s): _____		CPT Code(s): _____
Was patient hospitalized since last report? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Hospital name and Phone Number: <u>OHSU Portland, OR</u>		
Admission date: <u>03/18/19</u> Discharge date: <u>03/19/19</u>		
Has patient been referred to other physicians? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Date of Referral(s): _____		
Other Physician Name: <u>Kaiser Clinicians</u>	Phone Number: <u>() 503-813-2000</u>	Specialty: _____
Other Physician Name: _____	Phone Number: <u>()</u>	Specialty: _____

Apr 04 2019 15:29:24 EDT FROM: F2M/64357417503

MSG# 1716399754-006-1

PAGE 003 OF 003

Patient Name:

Date of Birth:

Insured ID Number:

Please complete this section to the best of your ability. Generalized comments such as "unable to work" may delay your patient's disability benefits.

Based on your most recent medical findings and opinion, address the full range of restrictions/limitations, noting that we will conclude there are no restrictions on function unless specified below.

Restrictions/Limitations based on office visit dated: 04/11/19 Expected Return to Work date: 05/06/19 est
In an 8 hour period the patient is able to: (select either continuous or intermittent)

	Continuously with standard breaks	or	Intermittently with standard breaks	If Intermittent circle time for each section below													
				Hours at one time								Total hours/8 hours					
Sit	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6
Stand	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6
Walk	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6

Provide medical findings/rationale for your opinion if patient is unable to continuously sit, stand or walk.

See DX

Activity Ability (with normal breaks)	Never 0 hours	Occasionally up to 2.5 hours	Frequently 2.5 to 5.5 hours	Constantly 5.5 to 8 hours	Please indicate diagnosis, symptoms, exam findings, and/or imaging that supports the restrictions/limitations
Bend at waist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneel/crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lift - Indicate weight in pounds		lbs.	lbs.	lbs.	
Other Restrictions (if any)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Hand Dominance: ☐ Right ☐ Left

Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral

Fine manipulation (fingering, keyboard)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gross manipulation (grip/grasp, handle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach (extend arms) above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach (extend arms) below shoulder at desk or workbench level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please attach copies of imaging results/tests

Expected duration of any restriction(s) or limitation(s) listed above: RTW 05/06/19 est

Current Status (Please check one): ☐ Recovered ☒ Improved ☐ Unchanged ☐ Retrogressed

Additional Comments (If Necessary):

Does the patient have a psychiatric / cognitive impairment? ☒ Yes ☐ No If "Yes," please describe the extent of the impairment and its etiology: Mild Cognitive Impairment

In your opinion is the patient competent to endorse checks and direct the use of the proceeds? ☒ Yes ☐ No

Provider's Name: (please print or type)

Bruce M Stelmack, DO

EIN Number:

REDACTED

License Number:

DO162043

Telephone Number:

(503) 571-5051

Fax Number:

(503) 571-2624

Degree:

DO

PHYSIATRY

Street Address (Street, City, State & Zip Code):

10220 SE Sunnyside Rd Clackamas, OR 97015

Office Contact and Telephone Number:

Bruce Stelmack

Digitally signed by Bruce Stelmack
Date: 2019.04.15 14:30:55 -0700

Provider's Signature:

Date signed:

Apr 04 2019 15:28:38 EDT FROM: F2M/64357417503

MSG# 1716399754-006-1

PAGE 001 OF 003



Request for Information

Date: 04/04/19 03:28:16 PM

To: Release of Information Department
Fax: 5035712624
Subject: Jennifer E Mueller 9005440032 - CAPS [HIGHLY RESTRICTED]

From: The Hartford
Fax: Please see attached form for fax number

Total Pages: 3 including cover page

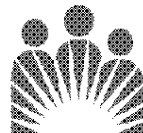
This facsimile message is intended ONLY FOR the use of the INDIVIDUAL OR ENTITY TO WHICH IT IS ADDRESSED, and MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL AND EXEMPT FROM DISCLOSURE under applicable law. IF the reader of this message is NOT THE INTENDED RECIPIENT, nor the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any DISSEMINATION, DISTRIBUTION OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. If you have received this communication in error, PLEASE NOTIFY US IMMEDIATELY BY TELEPHONE [confirm that telephone is provided on the communication], and return the original message.

We are faxing this form on behalf of your patient. Please complete the form in its entirety and fax it back to The Hartford. If you have any questions, please contact our office at 800-445-9057.

A decision is pending until this information is received so your prompt response is appreciated.

Thank you!

TIME RECEIVED	REMOTE CSID	DURATION	PAGES	STATUS
April 17, 2019 1:02:06 PM EDT	KPRFN003	181	4	Received
KPRFN003	4/17/2019 9:59:10 AM	PAGE 1/004	Fax Server	



KAISER PERMANENTE®

To: Hartford
Company: Hartford
Fax: 918664115613
Phone:

From: Brandie Sims, ROI Trainer; KPNW ROI Dept
Fax: 855-414-2792
Phone: 503-571-5083
E-mail: Brandie.M.Sims@kp.org

Subject:



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STD-AR-000128

From: informationupload@thehartford.com
Sent: Monday, April 01, 2019 12:45 AM
To: shared.eligib@hartfordlife.com
Subject: FW: Kaiser authorization (ROI)
Attachments: JMueller.Kaiser.Auth.pdf; ATT00001.htm

From: Jennifer Mueller
Sent: Monday, April 1, 2019 12:44:25 AM (UTC-05:00) Eastern Time (US & Canada)
To: informationupload (GB and WC Claims)
Subject: Kaiser authorization (ROI)

Attached is the signed Kaiser authorization form. Please let me know if you need anything else.

Jennifer Mueller
Claim 9005440032

Begin forwarded message:

From: Jon Nelson <postconsumer01@yahoo.com>
Date: March 31, 2019 at 1:07:39 PM PDT
To: Jennifer Mueller <madamezola@gmail.com>
Subject: your Kaiser Authorization form scan

This communication, including attachments, is for the exclusive use of addressee and may contain proprietary, confidential and/or privileged information. If you are not the intended recipient, any use, copying, disclosure, dissemination or distribution is strictly prohibited. If you are not the intended recipient, please notify the sender immediately by return e-mail, delete this communication and destroy all copies.



All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

Authorization for Kaiser Permanente to Use/Disclose Protected Health Information

1 PATIENT <u>Jennifer E. Mueller</u>		
NICKNAME / MAIDEN NAME / OTHER: _____		
HEALTH RECORD NUMBER <u>73745976</u>		
DATE OF BIRTH (MO/DAY/YR) <u>04/08/</u>	TELEPHONE NUMBER <u>503-217-9161</u>	
ADDRESS STREET OR BOX NUMBER: <u>4404 SW Carson St</u>		
CITY <u>Portland</u>	STATE <u>OR</u>	ZIP+4 <u>97219</u>

2 I authorize Kaiser Permanente to release the following information for: verification of medical condition
qualifying for short term disability

3 NAME OF PERSON TO RECEIVE INFORMATION <u>The Hartford</u>			
TITLE (PHYSICIAN, ATTORNEY, ETC): _____		PHONE NO.: <u>866-945-7801</u>	
STREET ADDRESS _____		CITY _____	STATE _____
		ZIP _____	

4 The purpose or need for the exchange and disclosure of this information is to:
1. Facilitate treatment; (2) Summarize treatment and/or; (3) Facilitate billing/reimbursement from insurance carriers.

5 Description of information to be used/disclosed (Be as specific as possible):

☒ All records

☐ X-ray films (describe): _____

☒ Other (describe): Include dental and OSHA records available through Care Everywhere

☐ Dental Only: _____

6 Media Type: Delivery Preference:
☒ Electronic ☐ Email/Secure Portal (Email address: _____)
☐ Paper ☐ Pickup ☐ Mail ☐ CD (Dental only)

7 If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I place my initials in the applicable space next to the type of information:

_____ Drug/Alcohol diagnosis, treatment or referral information

_____ HIV/AIDS information

_____ Mental Health information - including provider notes

_____ Genetic testing information

8 I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of drug/alcohol diagnosis, treatment or referral information, mental health information and genetic testing information.

Kaiser Permanente will not condition treatment, payment, enrollment, or eligibility for benefits on providing, or refusing to provide this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care service is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Kaiser Permanente, Release of Information Department at 10220 SE Sunnyside Rd., Clackamas, Oregon 97015 and state that you are revoking this authorization. To revoke this authorization orally, please call Release of Information Department at 503-571-5051 and state that you are orally revoking this authorization.

I have read this authorization and understand it. Unless revoked, this authorization expires in 12 months. In Washington, this authorization shall expire 90 days after the date signed if disclosure is to a financial institution or an employer for purposes other than payment.

A copy of this authorization is valid as an original. Member/patient has a right to a copy of this authorization.

9 X [Signature]
SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE

10 X 3/29/2019
DATE

X _____
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

From: informationupload@thehartford.com
Sent: Monday, April 01, 2019 12:45 AM
To: shared.eligib@hartfordlife.com
Subject: FW: Kaiser authorization (ROI)
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